IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
NORTHERN DIVISION

MARY TROUPE, ET AL.	)	
	)	
Plaintiff,	)	
	)	
v.	)	
	)	
	)	Civil Action No: 3:10CV153-HTW-LRA
GOV. HALEY BARBOUR, ET AL.	)	
	)	
Defendant.	)	
	)	

UNITED STATES' RESPONSE IN OPPOSITION TO STATE OF MISSISSIPPI'S MOTION FOR CONSOLIDATION

Mississippi's Motion to Consolidate, *United States v. Mississippi*, 3:16CV622-CWR-FKB, with *Troupe v. Barbour*, 3:10cv153HTW-MTP, should be denied.

1. These cases are factually and legally distinct and involve different plaintiffs. Consolidation would unduly prejudice the *United States* and adults with mental illness whose rights the United States seeks to vindicate, by delaying the proceedings and would not offer opportunities for reducing costs and judicial resources.

2. Consideration of consolidation is a two-step process: the judge in the second-filed action, here *United States v. Mississippi*, first determines whether there is a likelihood of substantial overlap between the two cases. It is only when the second court determines a likelihood of substantial overlap exists that the first-filed court weighs in to determine whether consolidation is warranted.

3. Although the State simultaneously filed its Motion for Consolidation in both courts, the Motion is first properly before the Court in *United States v. Mississippi*.

4. A trial court has broad discretion in determining whether to consolidate a case pending before it. Under Rule 42(a), when separately filed actions "involve a common question of law or fact," a court "may" consolidate the actions.

5. As set forth in the United States' Memorandum of Law in Support of Its Response in Opposition to the State of Mississippi's Motion for Consolidation, there are no common issues of fact or law here. The two cases are factually distinct and will require separate discovery, dispositive motions, factual findings, witnesses, trial, and remedies. The legal issues presented in these cases are also different because they arise from a different set of facts. Finally, the United States is *not* a party to *Troupe;* nor are *Troupe* plaintiffs a party to the United States' case.

6. For support, the United States attaches the exhibits listed below and files a Memorandum of Law in Support of this Response:

Exhibit 1 – *Troupe v. Barbour* Complaint

Exhibit 2 – *United States v. State of Mississippi* Complaint

Exhibit 3 – Mississippi Department of Mental Health, Think Recovery 1 (2015)

Exhibit 4 – Mississippi Department of Mental Health, FY 2016-2017 State Plan

7. The United States respectfully requests that the Court DENY the State's Motion and not transfer or consolidate this case with *Troupe*.

Respectfully submitted,

FOR THE UNITED STATES:

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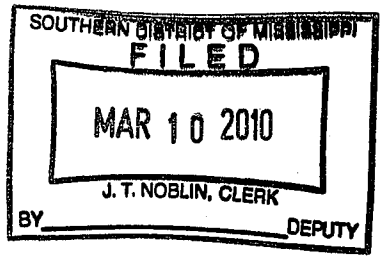
CERTIFICATE OF SERVICE

I, Elizabeth C. Kelley, Attorney for the United States, hereby certify that I electronically filed the foregoing with the Clerk of the Court using the ECF system which sent notification of such filing to all parties.

THIS 7th day of November, 2016.

/s/ Elizabeth C. Kelley
Elizabeth C. Kelley (VA Bar #80255)

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
JACKSON DIVISION



J.B. and L.P., by and through their next friend, Mary Troupe; L.M., by and through his next friend, Trasie Howard; and L.S., by and through his next friend, Sheila Davis,

Plaintiffs,

v.

GOVERNOR HALEY BARBOUR, in his official capacity; ROBERT L. ROBINSON, in his official capacity as Director of the Mississippi Division of Medicaid; PATRICIA AINSWORTH, in her official capacity as chair of the Mississippi Board of Mental Health; and EDWIN C. LEGRAND, in his official capacity as Executive Director of the Mississippi Department of Mental Health,

Defendants.

Case No. 3:10 CV 153 HTW-LRA

COMPLAINT FOR INJUNCTIVE AND DECLARATORY RELIEF

INTRODUCTORY STATEMENT

1. Thousands of children and youth in Mississippi have a behavioral or emotional disorder. Tragically, all too many of these children spend their formative years isolated from their families and communities as they cycle through institutions that cannot provide them adequate care. Children in Mississippi with behavioral and emotional problems face a rigid, facility-based mental health system that both ignores and exacerbates their needs. In order to access intensive mental health services in Mississippi, children must either deteriorate to the point of crisis required for involuntary hospitalization, or submit to unnecessary institutionalization. Both scenarios force children to relinquish their families, communities, and freedom, and endure

isolation, multiple placements, and severed connections, making even more challenging the task of helping these children overcome their difficulties. The failure to provide children with intensive mental health services in a home or community-based setting denies children medically necessary services and results in needless institutionalization, in violation of federal law. Mississippi's taxpayers are thus forced to shoulder the burden of an expensive and ineffective mental health system that greatly diminishes the quality of life and human potential of thousands of children across the State. Providing children with medically necessary home- and community-based services, rather than relying exclusively on hospitals and institutions, would save the State and its taxpayers a significant amount of money and improve the life chances of thousands of children in Mississippi.

2. The Defendants are well-aware that the mental health system fails to provide medically necessary home- and community-based mental health services, and subjects children to harmful and unnecessary institutionalization. A 2008 report from a committee of the State Legislature describes the dramatic shift from an institution-based system to a community-based system of mental health care in the United States, and warns that "[a]s of 2005, Mississippi still ha[s] yet to follow the national trend set over fifteen years ago of devoting the majority of its mental illness expenditures to community-based services." Joint Legislative Committee on Performance Evaluation and Expenditure Review (PEER), *Report to the Mississippi Legislature, Planning for the Delivery of Mental Health Services in Mississippi: A Policy Analysis* 29 (Jun 26, 2008), available at: http://www.peer.state.ms.us/reports/rpt511.pdf. Contrary to this national trend, Mississippi continued to build new institutions into the 1990s, well after most other states turned their resources to community-based services, and Mississippi ranks second nationally in per-capita spending for institution-based mental health care. *Id.* at 28. The report warns that the

U.S. Supreme Court's 1999 holding in *Olmstead v. L.C., ex rel. Zimring,* 527 U.S. 581 (1999) will require the State to move toward providing more community-based services in the near future. *Id.* at 33.

3. As a result of Defendants' continued over reliance on institutions, hundreds of children with behavioral and emotional disorders cycle through hospitals, emergency rooms, acute care facilities, and residential treatment centers without obtaining any long-term relief. These placements may offer a brief period of respite, but the benefits are fleeting at best. Mississippi's system of mental health care is so weak and uncoordinated that most children are released from facilities with little or ineffective follow-up community mental health care. It can take months to get an appointment from a community mental health center, and when services finally arrive, they consist of little more than minimal medication management and outpatient counseling two times a month, which is inadequate for a child with significant behavioral and emotional problems. Not surprisingly, many children and families find themselves thrown back into a crisis, forced to repeat the cycle of institutionalization yet again. Under the current system, Defendants opt to raise children living with behavioral and emotional problems in hospitals and institutions, rather than providing the intensive, individualized care that allows children to remain in their homes and communities.

4. J.B., L.P., L.M., and L.S. and the class they represent are Medicaid-eligible children who have behavioral or emotional disorders, but who are not being provided with the treatment required by federal law. As Medicaid-eligible children under the age of twenty-one, Plaintiffs are entitled to receive Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT Services) which include services necessary to correct or ameliorate mental health conditions. 42 U.S.C. § 1396a(a)(43)(C); 42 U.S.C. § 1396d(a)(4)(B); 42 U.S.C. § 1396d(r)(5); 42 C.F.R. §

441.55. Despite widespread agreement among mental health experts that children with significant emotional or behavioral problems need intensive home- and community-based services, none of the named Plaintiffs have ever received such services; and all have been, or currently are, segregated in a restrictive institutional setting due to the lack of medically necessary services. Each Plaintiff has been and is being harmed because s/he is not receiving medically necessary mental health services and is needlessly institutionalized or at risk of needless institutionalization. The continued denial of medically necessary services, as well Defendants' reliance on unnecessary institutionalization, has caused and will continue to cause serious, long term and irreversible harm to the Plaintiffs.

5. The Plaintiffs seek prospective injunctive relief ordering the Defendants to comply with federal law mandates to provide Plaintiffs medically necessary mental health services and to serve Plaintiffs in home and community settings. The violations set forth in this Complaint have been acknowledged by the state legislature, mental health professionals, and the Defendants themselves, but little has been done to address the problem. Declaratory and injunctive relief is necessary to ensure that the Plaintiffs receive the treatment and services to which they are entitled by law.

PARTIES

Individual Plaintiffs

6. Plaintiff J.B. is a seventeen year old boy who has experienced over ten placements in psychiatric hospitals and long-term residential treatment facilities and is currently committed to the Specialized Treatment Facility in Gulfport, MS. J.B. is from North Central Mississippi, and he brings this action through his next friend, Mary Troupe.

7. L.P. is a seventeen year old girl who has experienced a number of psychiatric hospitalizations. L.P. is from the Jackson metropolitan area and is currently committed to the Specialized Treatment Facility in Gulfport, MS. She brings this action through her next friend, Mary Troupe.

8. L.M. is a sixteen year old boy who has experienced six psychiatric hospitalizations and one long-term placement in a psychiatric treatment facility. L.M. resides in the Mississippi Delta. He brings this action through his mother and next friend, Trasie Howard.

9. L.S. is a thirteen year old boy who has been placed in long-term psychiatric residential treatment facilities on three separate occasions. He is from Southwest Mississippi and currently resides at the CARES Center in Jackson, Mississippi. He brings this action through his legal guardian and next friend, Sheila Davis.

10. All Plaintiffs need but are currently being denied intensive home- and community-based mental health services. All are currently institutionalized or at imminent risk of being institutionalized as a result of being denied the intensive home- and community-based mental health services they need.

Defendants

11. Defendant Haley Barbour is the Governor of Mississippi, a public entity covered by Title II of the ADA, 42 U.S.C. § 12131(1) and a participant in the federal Medicaid program. Defendant Barbour, as supreme executive officer of the state, is responsible for ensuring that all Mississippi agencies comply with applicable federal law. Miss. Code Ann. § 7-1-5 (a)(c). Defendant Barbour is responsible for supervising the official conduct of all executive offices—including the Department of Mental Health, the State Board of Mental Health, and the Division of Medicaid. Miss. Code Ann. § 7-1-5 (d). Defendant Barbour appoints the members of the

State Board of Mental Health, Miss. Code Ann. § 41-4-3(1); appoints the Executive Director of the Division of Medicaid, which is a division of the Governor's Office, Miss. Code Ann. § 43-13-107, and approves all Medicaid expenditures. Miss. Code Ann. § 43-13-117(A). Defendant Barbour is sued in his official capacity.

12. Defendant Robert L. Robinson is the Executive Director of the Mississippi Division of Medicaid, the single state agency responsible for the administration of the Mississippi Medicaid program. Defendant Robinson oversees the development and execution of Mississippi's Medicaid Plan and all Medicaid policies and procedures, including those regarding services for children with behavioral or emotional disorders. Miss. Code Ann. § 43-13-107, § 43-13-117. Defendant Robinson is also responsible for ensuring that Mississippi's Medicaid program operates in compliance with state and federal law. Defendant Robinson is sued in his official capacity.

13. Defendant Patricia Ainsworth is the Chair of the State Board of Mental Health, and is responsible for appointing a full-time Executive Director of the Department of Mental Health, which administers mental health services for children. Defendant Ainsworth and the State Board of Mental Health are responsible for establishing and administering all mental health services on a state and regional level for the State of Mississippi; and supervising, coordinating and establishing standards for all operations and activities in Mississippi related to mental health and the provision of mental health services, including those regarding services for children with behavioral or emotional disorders. Miss. Code Ann. § 41-4-7. Defendant Ainsworth is sued in her official capacity.

14. Defendant Edwin C. LeGrand serves as the Executive Secretary of the State Board of Mental Health and is the Executive Director of the Mississippi Department of Mental Health, the

state agency responsible for administering, coordinating, developing, improving, and planning all services for individuals living with mental illness in Mississippi. Miss. Code Ann. § 41-4-1. Defendant LeGrand is responsible for establishing and administering all mental health services on a state and regional level for the State of Mississippi; supervising, coordinating and establishing standards for all operations and activities in Mississippi related to mental health and the provision of mental health services, including those regarding services for children with behavioral or emotional disorders, Miss. Code Ann. § 41-4-7; obtaining funds from the State Legislature for Medicaid services; and organizing programs and services in a manner that maximizes funding through the Division of Medicaid. Miss. Code Ann. § 43-13-111. Defendant LeGrand is sued in his official capacity.

JURISDICTION AND VENUE

15. This is a class action lawsuit authorized by 42 U.S.C. § 1983 to redress the ongoing deprivation under color of state law of rights guaranteed by the United States Constitution and federal statutes. This Court has jurisdiction pursuant to 28 U.S.C. §§ 1331 and 1343.

16. Venue is proper pursuant to 28 U.S.C. § 1391(b) because a substantial part of the events or omissions giving rise to the claims herein occurred in this district, and because all Defendants named herein reside in, maintain offices in, or are responsible for enforcing the laws relevant to this litigation in this district.

CLASS ALLEGATIONS

17. This action is properly maintained as a class action pursuant to Rule 23(a) and (b)(2) of the Federal Rules of Civil Procedure. Plaintiffs represent a statewide class of Medicaid-eligible children under the age of twenty-one who have a behavioral or emotional disorder and who need intensive home- and community-based mental health services. "Intensive home- and

community-based services" includes: a comprehensive assessment, intensive case management services, mobile crisis services, in-home therapy, behavioral support services, family education and training, and therapeutic foster care.

18. The size of this class is so numerous that joinder of all members is impracticable. There are thousands of children with an emotional or behavioral disorder in Mississippi. In 2009, over 1300 children and youth were placed in a psychiatric residential treatment facility or therapeutic group home; and in 2008 over 700 children were committed to a state hospital. The great majority of these children could and should have been served instead in their own homes or in a therapeutic foster home.

19. There are questions of law and fact common to all class members, including:

a) whether Defendants' failure to provide medically necessary intensive home- and community-based services violates the EPSDT mandate of Title XIX of the Social Security Act;

b) whether Defendants violate the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act by failing to provide mental health services in the most integrated setting.

20. The claims of the named Plaintiffs are typical of the claims of the Plaintiff class. As a result of the Defendants' policies, practices, and procedures, the individual Plaintiffs and class members are not provided with intensive home-based and community-based services to treat or ameliorate their behavioral or emotional disorders; and are currently segregated, or at risk of segregation, due to Defendants' failure to provide medically necessary and legally mandated services.

21. The named Plaintiffs will fairly and adequately represent the interests of the class. They possess a strong personal interest in the subject matter of the lawsuit, and are represented by experienced counsel with expertise in class action litigation on behalf of children and

adolescents in federal court. Counsel have the legal knowledge and the resources to fairly and adequately represent the interests of all class members in this action. Fed. R. Civ. P. 23(a)(4).

22. Defendants have acted and refuse to act on grounds generally applicable to the class in that Defendants' policy and practice of violating the Plaintiffs' rights has affected all class members. Accordingly, final injunctive and declaratory relief is appropriate for the class as a whole.

CONSTITUTIONAL AND STATUTORY BACKGROUND

A. The Federal Medicaid Program

23. Medicaid is a voluntary, cooperative, federal-state program under Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.,* designed to provide medically necessary health and mental health care to, among others, low-income children and families.

24. Participation in the Medicaid program is voluntary; and states that choose to participate receive federal matching funds for their own programs. To receive federal matching funds, states must adhere to the requirements set forth in Title XIX of the Social Security Act and its implementing regulations. 42 C.F.R. §§ 430.0 *et seq.* In addition, states must have a state plan that describes their administration of the program and identifies the services they will provide to eligible beneficiaries. 42 U.S.C. § 1396a.

25. Federal law requires states to fully implement the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program of Medicaid. 42 U.S.C. § 1396a(a)(43); 42 U.S.C. § 1396d(a)(4)(B); 42 U.S.C. § 1396d(r). The purpose of the EPSDT program is to ascertain children's physical and mental health conditions and ensure children receive needed services "to correct or ameliorate defects and physical and mental illnesses and conditions . . . ." 42 U.S.C. § 1396d(r)(5). Under EPSDT, states are required to provide screening services to identify health

and mental health conditions and illness. 42 U.S.C. § 1396d(r)(1). States must also provide needed diagnostic and treatment services to correct or ameliorate health or mental health conditions. 42 U.S.C. § 1396a(a)(43)(C); 42 U.S.C. § 1396d(r)(5). Needed services must be provided whether or not such services are included in the state plan. 42 U.S.C. § 1396d(r)(5); 42 C.F.R. § 441.56(c).

26. Mississippi has chosen to participate in the Medicaid program; and therefore must provide EPSDT services to eligible children under the age of 21.

27. For children with significant emotional and behavioral disorders, intensive home- and community-based services are medically necessary to treat and ameliorate their disorders.

28. Intensive home- and community-based services are typically designed and supervised by a "child and family team." By their nature, such services are flexible and individualized, aimed at improving functioning in the home, in school, and in the community. They include, but are not limited to, a comprehensive assessment, intensive case management services, mobile crisis services, in-home therapy, behavioral support services, family education and training, and therapeutic foster care.

29. Mississippi has not included intensive home-and community-based services in its state Medicaid plan; nor does Mississippi otherwise make intensive home- and community-based services available on a consistent, statewide basis to children for whom the services are medically necessary. Outside of its Medicaid program, Mississippi offers a limited amount of intensive home- and community-based services to a limited number of children in limited areas of the state, through a federal demonstration grant program called MYPAC. To be eligible, a child must meet the clinical criteria for admission to a psychiatric residential treatment facility; and MYPAC has an upper limit on the number of children it can serve each year. MYPAC does

not provide therapeutic foster care services.[1] Currently, 180 youth are enrolled in the program. During the last fiscal year, fewer than 200 children received services through MYPAC. In contrast, close to 2,000 youth received mental health services in an institutional setting during the last fiscal year: 557 children were committed to a state hospital, 888 were placed in a psychiatric residential treatment facility, 476 were placed in a therapeutic group home, and hundreds more cycled through emergency rooms and other acute care facilities for crisis care and treatment.

B. The Americans with Disabilities Act and Section 504 of the Rehabilitation Act

30. Title II of the Americans with Disabilities Act prohibits public entities from discriminating against or excluding a qualified individual with a disability from participating in the benefits of services, programs, or activities of the public entity on the basis of disability. 42 U.S.C. § 12132; 28 C.F.R. § 35.130.

31. The ADA requires public entities to administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities. 28 C.F.R. § 35.130(d).

32. Public entities also must make reasonable modifications in polices, practices, or procedures when necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that the modifications would fundamentally alter the nature of the service, program, or activity. 28 C.F.R. § 35.130(b)(7).

33. Section 504 of the Rehabilitation Act, 29 U.S.C. § 794, imposes identical requirements on state programs and activities that receive federal financial assistance.

[1] A limited number of children in the custody of the Mississippi Department of Human Services have access to therapeutic foster care. However, these foster homes do not provide intensive services and supports; and therapeutic foster care is not available as a Medicaid-covered service.

34. The Defendants discriminate against the named Plaintiffs and the Plaintiff class by failing to provide them services in the most integrated setting appropriate to their needs. An integrated setting is one that allows individuals to live in their home or a home-like setting with natural family supports and the opportunity to attend school and participate in their communities with non-disabled peers. Defendants offer only a negligible amount of intensive home- and community-based services to children and have chosen instead to serve children in needlessly segregated settings.

35. Hospitals, psychiatric residential treatment facilities, and group homes are all restrictive settings that severely limit a child from interacting with her family, school, peers, and community. Additionally, out-of-home placements exacerbate many children's behavioral and emotional problems by severing these important connections. By failing to provide adequate home-based and community-based mental health services, the Defendants have and continue to discriminate against the Plaintiff class by unnecessarily segregating them in violation of the ADA and Section 504.

STATEMENT OF FACTS

A. The Crisis for the Plaintiff Class

36. The evidence from mental health and child welfare experts is clear that intensive home- and community-based services are medically necessary for children with significant behavioral or emotional disorders. *See generally Community Treatment for Youth: Evidence-Based Interventions for Severe Emotional and Behavioral Disorders* (Barbara J. Burns & Kimberly Hoagwood eds., 2002). These services, which are mandated by law, include a comprehensive assessment, typically by a child and family team, intensive case management services, mobile

crisis services, in-home therapy, behavioral support services, family education and training, and therapeutic foster care.

37. The evidence is equally clear that institutional care not only fails to meet children's needs, but is often counterproductive and harmful. Institutional care deprives children of normalizing experiences, isolates them with other children who have behavior problems, and exacerbates feelings of anxiety and concern. Subjecting children with mental illness to unnecessary institutional care constitutes discrimination in violation of federal law.

38. Notwithstanding the overwhelming evidence supporting the need for intensive home- and community-based services, Defendants have failed to provide these services to the named Plaintiffs and class members.

39. The majority of children with significant behavioral or emotional disorders seek services through their regional community mental health center. These centers are certified and overseen by Defendants. Intensive home-based and community-based services are not available through these centers.[2] The majority of children served by the centers receive infrequent office-based therapy or counseling and medication, which alone are inadequate to meet the needs of children with significant behavioral or emotional disorders. Some community mental health centers are open only a few days a week.

40. Instead of providing intensive home- and community- based services, Defendants have relied on institutional settings where children with behavioral or emotional disorders are segregated for extended periods of time, often far from their home. Mississippi's mental health care system is so highly reliant on institutional care that children with significant behavioral or

[2] The exception to this is the Pine Belt Mental Health Center, which provides some intensive home-based and community-based services through a federal system of care grant called commUNITY Cares. However, very few children receive these services. The Pine Belt Mental Health Center covers nine counties and serves over 3,000 children and youth.

emotional disorders can expect to make the rounds of at least two state-run facilities, two to three private facilities, and a handful of emergency rooms, acute care facilities, and therapeutic group homes. This adds up to years of institutionalization before a child's twenty-first birthday, and severe and permanent disruptions to their family, education and personal development.

41. Even when a child experiences some benefits from institutional care, these gains dissipate quickly upon discharge because the community mental health system is so weak and fragmented. The Defendants' discharge planning for children leaving the State's institutions consists of nothing more than a referral to the local community mental health center, where it can take weeks to get an appointment, and care is limited to infrequent outpatient counseling and medication. Consequently, children return to their families' care with little services or supports. Not surprisingly, many children quickly deteriorate, only to face another traumatic cycle of institutionalization and isolation.

B. The Crisis for Individual Plaintiffs

42 Plaintiff **J.B.** is a seventeen year-old boy from North Central Mississippi who has been in the state's foster care system since he was old enough to walk. The Department of Human Services initially removed J.B. from his home on account of abuse and neglect by his mother.

43. In J.B.'s thirteen years in the foster care system, he has been hospitalized at least five times, placed in six different foster homes, five residential treatment facilities, more than ten group homes and shelters, and locked in a secure detention facility on at least twelve occasions when a group home or shelter could not handle J.B.'s behavioral and emotional problems. J.B.'s "problem behaviors" have been described as "multiple hospitalizations" and "unsuccessful foster placements." J.B. needs but has never received intensive home-based and community-based services.

44. DHS attempted to reunify J.B. with his mother in 2009; however, he was removed and placed in a group home after he contacted the police to break up a fight between his mother and her boyfriend. The group home asked J.B. to leave because of his difficulty controlling his behavior. When J.B. ran away, he was placed in a secure detention facility until a bed became available for him at a private mental health facility. He was then committed to the Specialized Treatment Facility ("STF") in May, 2009.

45. J.B. is currently in the physical custody of the Department of Mental Health, which operates STF The examining physician who certified J.B.'s placement in a residential facility did not identify a medical need for residential placement, but rather stated that residential treatment was necessary because J.B.'s mother had resumed drinking and could not offer a stable environment.

46. During his intake interview at STF, J.B. stated that his three wishes in life are: "To rewind time. To show my mama that I can be a better child. To be independent and on my own." J.B. just graduated from high school with an occupational diploma. While at STF, J.B. has written an autobiography to memorialize both the meaningful and traumatic events in his life, which he hopes to publish one day.

47. J.B. apparently remains confined to STF so he can complete one month of a job-training program –an activity that could easily be accommodated if he lived in a home- or community-based setting.

48. J.B. will not receive intensive home-based and community-based services upon discharge from STF. J.B.'s community mental health center does not offer such services.

49. Plaintiff **L.P.** is a seventeen year old girl from the Jackson metropolitan area, and was placed in DHS custody in August 2009 when it was discovered that she had been sexually abused.

50. L.P. has an extensive history of abuse and trauma. Beginning at a young age, she was sexually abused by a male relative, and other men. L.P. began to display emotional and behavioral problems around the age of eight. Her symptoms worsened over time, until she was hospitalized at the age of ten. Since that time, L.P. has been hospitalized four more times and placed in a long-term residential treatment facility, but has never received intensive home-based and community-based services. These intensive services are not offered by her community mental health center.

51. L.P. is a good student, earning A's and B's, and has successfully maintained a job at a fast food restaurant. Her wishes in life include: "For my family to be back to normal. A place for me to live, so it can be like the loving family that I have always wanted."

52. DHS placed L.P. in a foster home in August, 2009, after a period of hospitalization. When L.P. ran away from the foster home, she was held in a maximum security detention facility for two weeks until she was committed to the state psychiatric hospital for expressing suicidal thoughts. L.P.'s foster care caseworker described her chief problem as "depression, anxiety – lack of supervision." L.P.'s state hospital discharge plan was for L.P. "to go to long-term residential treatment."

53. After stabilizing at the state hospital, L.P. was transferred to STF, where she recently obtained her G.E.D. Her discharge plan suggests that L.P. live with her father, but does not include any arrangements to connect L.P. with needed intensive home-based and community-based services.

54. Plaintiff **L.M.** is a sixteen year old boy with bipolar disorder and a history of sexual trauma. L.M. has been hospitalized four times and placed in long-term residential treatment. He is currently living with his mother in the Delta, and is not receiving intensive mental health services.

55. L.M. experienced a succession of traumatic events before his thirteenth birthday. L.M. was molested at age seven, and shortly after that he began to display disruptive behaviors at home and school. When L.M. was ten, his father died unexpectedly; and the next year L.M. endured more sexual abuse and was hospitalized for mental health treatment. When he was thirteen, he discovered his grandmother's body after she passed away, and he lost both his aunt and uncle the following year. L.M.'s behavior at home and school became increasingly challenging, and he was hospitalized in acute care facilities throughout his early teens when his mother could no longer handle his behavior at home.

56. Despite trauma and disruptions to his life, L.M. remains a lively, outgoing child who enjoys dancing and superman. L.M. has a passion for baking pastries and desserts, which he learns to make by watching cooking shows on television. His dream in life is to attend culinary school to become a pastry chef.

57. L.M. has not received intensive home-based and community-based services, but he has spent years of his life in segregated, institutional settings. In addition to five hospitalizations in acute psychiatric facilities, L.M. was committed to the state hospital for five months in February, 2008. At the end of his commitment, Defendants transferred L.M. to STF, where he stayed for close to a year. L.M.'s discharge plan from STF consisted of a referral to his community mental health center, which does not provide intensive home-based and community-based services. When L.M.'s behavior deteriorated within a few months of his discharge, he was hospitalized for

two weeks and committed to the state's juvenile training school less than two months later because L.M. had exhausted other institutional options. L.M. was recently released from the training school, but has not been provided with the intensive mental health services he needs.

58. Plaintiff **L.S.** is a twelve year old boy from Southwest Mississippi. He is currently placed at the CARES Center, a private residential treatment center in Jackson, Mississippi – close to two hours away from his home.

59. L.S. entered the foster care system at the age of four after a family tragedy. L.S. was eventually placed in the custody of his aunt, who is now his legal guardian.

60. L.S. began to display behavioral and emotional problems at a young age, and was hospitalized at the age of eight, and again at age nine. He was placed in a private residential treatment center when he was ten, and is currently on his third placement in a long-term residential treatment center.

61. L.S. has received only limited outpatient counseling and medication management from his community mental health center, which is only open two days per week

62. L.S. recently told his therapist that his favorite thing to do is visit friends and family. L.S. wants to return to his home, and his aunt worries about the disruption and distance imposed by his placement so far away. L.S.'s aunt wants L.S. to return home, but L.S. needs intensive home-based and community-based services to support this transition.

CAUSES OF ACTION

Count I – EPSDT Services, 42 U.S.C. § 1396d *et seq.*

63. Plaintiffs incorporate by reference the foregoing paragraphs of this Complaint as though fully set forth herein.

64. In violation of the EPSDT provisions of the Medicaid Act, Defendants, while acting under the color of law, have failed to provide Plaintiffs with medically necessary intensive home- and community-based mental health services when such services are medically necessary to treat or ameliorate their conditions. 42 U.S.C. § 1396a(a)(43), § 1396d(r).

65. Defendants failure to provide statutorily-mandated mental health services violates 42 U.S.C. § 1983 by depriving Plaintiffs of their statutory rights under the Medicaid Act to receive medically necessary mental health services.

Count II – Americans with Disabilities Act and Section 504 of the Rehabilitation Act

66. Plaintiffs incorporate by reference the foregoing paragraphs of this Complaint as though fully set forth herein.

67. Children with behavioral or emotional disorders are qualified individuals with disabilities within the meaning of the ADA, and are "otherwise qualified individuals with a disability" within the meaning of the Rehabilitation Act.

68. Defendants are public entities subject to the provisions of the ADA. Defendants receive federal financial assistance, and are thus subject to the provisions of the Rehabilitation Act.

69. Defendants have failed to administer services, programs, and activities in the most integrated setting appropriate to the needs of children with emotional or behavioral disorders. Defendants have discriminated against these children by needlessly placing them in institutional settings to receive mental health care. While in these settings, children are segregated from the community and prevented from maintaining meaningful contact with their families, schools, and communities.

70. The relief sought by Plaintiffs would not require the creation of services that are new to Mississippi or inconsistent with Mississippi's stated public policies. Defendants claim to support

and embrace the reforms sought by Plaintiffs in this case. The relief sought would further the Defendants' stated goal to convert to a community-based system of mental health care. Moreover, the relief sought by Plaintiffs would not impose unreasonable additional costs on Defendants' service system. Defendants are already legally mandated to provide Plaintiffs intensive home-based and community-based services. Furthermore, the relief sought by Plaintiffs could be funded by the savings Mississippi would realize from reduced reliance on institutional care. Accordingly, the relief sought by Plaintiffs would not amount to a fundamental alteration within the meaning of the ADA or Section 504.

REQUEST FOR RELIEF

WHEREFORE, the plaintiffs respectfully request that this Court:

1. Certify this case as a class action pursuant to Fed. R. Civ. P. 23;
2. Declare unlawful Defendants' failure to comply with the mandates of the Medicaid Act, the Americans with Disabilities Act, and Section 504 of the Rehabilitation Act;
3. Enter a preliminary and permanent injunction enjoining Defendants from subjecting members of the Plaintiff class to practices that violate their rights under the Medicaid Act, the Americans with Disabilities Act, and Section 504 of the Rehabilitation Act;
4. Award to the Plaintiffs the reasonable costs and attorney's fees incurred in the prosecution of this action;
5. Award such other equitable and further relief as the Court deems just and proper.

RESPECTFULLY SUBMITTED, this the 10 day of March, 2010.

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CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing document has been served

by hand delivery on:

Harold Pizzetta, III
Special Assistant Attorney General
Chief, Civil Litigation Division
Mississippi Office of the Attorney General
Walter Sillers Building
550 High Street, Suite 1200
Jackson, MS 39201

This 10 day of March, 2010.

Vanessa Carroll, Miss. Bar No. 102736

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
NORTHERN DIVISION

THE UNITED STATES OF AMERICA,

Plaintiff,

v.

THE STATE OF MISSISSIPPI,

Defendant.

COMPLAINT
Civil Action No: 3:16cv622 CWR FKB

INTRODUCTION

1. The United States brings this action against the State to enforce the rights of adults with mental illness to receive services in the most integrated setting appropriate to their needs. The State discriminates against adults with mental illness by administering and funding its programs and services for these individuals in a manner that has resulted in their repeated, prolonged, and unnecessary institutionalization in state-run psychiatric hospitals, and placed them at serious risk of such institutionalization, in violation of Title II of the Americans with Disabilities Act of 1990 (the "ADA"), 42 U.S.C. §§ 12131-12134.

2. Every day, hundreds of adults with mental illness are unnecessarily and illegally segregated in Mississippi's state-run psychiatric hospitals or are at serious risk of entering these institutions. They enter and remain in these isolating institutions because the State of Mississippi ("the State") has failed to provide them sufficient community-based mental health services.

3. While confined in these institutions, adults with mental illness are unnecessarily cut off from non-disabled family and friends and others in the community.

4. By virtue of their institutionalization, these adults with disabilities are deprived of meaningful opportunities to choose friends, work, or make choices about their day to day activities, such as what and when to eat, when to make a phone call, and where to go on a walk.

5. These individuals experience the type of "[u]njustified isolation" that the Supreme Court held "is properly regarded as discrimination based on disability." Olmstead v. L.C., 527 U.S. 581, 597 (1999).

6. Title II of the ADA prohibits the unjustified segregation of persons with disabilities, see 42 U.S.C. § 12132; Olmstead, 527 U.S. at 597, and requires states and other public entities to "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d) (2010).

7. Life in an institution leads not only to stigma and isolation, but also regression, learned helplessness, and physical harm. It is well-recognized that integrated, community-based services enhance and support recovery from mental illness.

8. In 2003, the President of the United States put together a committee tasked with studying the nation's mental health service delivery system and making recommendations that would enable adults with serious mental illness to live, work, learn, and participate fully in their communities. The committee concluded that "[m]ore individuals could recover from even the most serious mental illnesses if they had access in their communities to treatment and supports that are tailored to their needs." New Freedom Commission on Mental Health, Achieving the Promise: Transforming Mental Health Care in America, Final Report 5, Pub. No. SMA03-3831 (2003).

9. In the community, individuals have the opportunity to learn and practice skills that enable independence. Further, people typically prefer to live in the community, and are more motivated to engage in treatment in their homes.

10. The State of Mississippi has long recognized that it unnecessarily relies on institutions and fails to provide sufficient services to enable adults with mental illness to live in the community.

11. In 2008, the Mississippi Legislature's Joint Committee on Performance Evaluation and Expenditure Review ("PEER") found that "[a]lthough the mental health environment in the United States has dramatically changed from an institution-based system to a community-based system in recent years, Mississippi's mental health system has not reflected the shift in service delivery methods." Joint Legislative Committee on PEER, Report to the Miss. Legislature No. 511, Planning for the Delivery of Mental Health Services in Mississippi: A Policy Analysis 1 (2008). A year ago, the same Committee recommended that "[t]he Department of Mental Health and Mississippi State Hospital should gather the appropriate data sets regarding the mental health needs of the hospital, the communities, and the state in order for the department to articulate its community-based services strategy, design its implementation process, and reallocate its resources." Joint Legislative Committee on PEER, Report to the Miss. Legislature No. 593, Staffing of Psychologists at the Mississippi State Hospital in a Changing Mental Health Service Delivery Environment 1 (2015).

12. Mississippi continues to concentrate its State spending on mental health on institutional care.

13. In fiscal year 2015, the Mississippi Department of Mental Health spent $202.5 million on its state hospitals, which include the Mississippi State Hospital, North Mississippi State Hospital,

East Mississippi State Hospital, and South Mississippi State Hospital. It provided about $25 million in grants for intensive community-based services that could be used to divert people from hospitals and support those individuals in the community that year.

14. Community-based mental health services include psychiatric services, individual and group therapy, intensive case management, crisis services, peer support services, Assertive Community Treatment, supported employment, and permanent supported housing.

15. These community-based services for adults with mental illness already exist within Mississippi's mental health service system, but they are not provided uniformly throughout the State's system and even where they are available, they are not available in sufficient quantities to meet the need.

16. If administered appropriately, these community-based services would be both cost-effective and capable of meeting the needs of adults with mental illness.

17. The United States seeks to vindicate the rights of adults with mental illness in Mississippi's state-run psychiatric hospitals, and those at serious risk of entry into these institutions.

JURISDICTION AND VENUE

18. This Court has jurisdiction over this action under Title II of the ADA, 42 U.S.C. § 12133, and 28 U.S.C. §§ 1331, 1345. The Court may grant the relief sought in this action pursuant to 28 U.S.C. §§ 2201-2202. The United States has the authority to seek a remedy for violations of Title II of the ADA, 42 U.S.C. §§ 12133-12134; 28 C.F.R. §§ 35.170-174, 190(e).

19. The United States is authorized to initiate this action pursuant to the Civil Rights of Institutionalized Persons Act of 1980 ("CRIPA"), 42 U.S.C. § 1997.

20. The Attorney General has certified that all pre-filing requirements specified in 42 U.S.C. § 1997b have been met. The Certificate of the Attorney General is appended to this Complaint as Attachment A and is incorporated herein.

21. Venue is proper in this district pursuant to 28 U.S.C. § 1391(b), given that a substantial part of the acts and omissions giving rise to this action occurred in the Southern District of Mississippi.

PARTIES

22. Plaintiff is the United States of America.

23. Defendant, State of Mississippi, is a "public entity" within the meaning of the ADA, 42 U.S.C. § 12131(1), and is therefore subject to Title II of the ADA, 42 U.S.C. § 12131 et seq., and its implementing regulations, 28 C.F.R. pt. 35.

24. The State of Mississippi owns and operates four psychiatric hospitals, which are institutions under the meaning of 42 U.S.C. § 1997(1). The State administers and funds services for adults with mental illness through various agencies and departments.

25. Mississippi's Division of Medicaid manages the State's Medicaid program, which includes coverage of mental health services to Medicaid-enrolled adults with mental illness.

26. Mississippi's Department of Mental Health is the state agency responsible for providing mental health services to the citizens of Mississippi.

27. As part of its mental health system, the Department of Mental Health provides state-funded, state-run psychiatric residential services for adults with mental illness at four psychiatric hospitals and one residential center.

28. The Department of Mental Health also regulates, oversees, and provides funding for community-based mental health services for adults with mental illness.

29. The Mississippi Home Corporation was created by the Mississippi Home Corporation Act of 1989 to address affordable housing needs in Mississippi. The Mississippi Home Corporation is Mississippi's designated Housing Finance Agency and is responsible for developing private and public partnerships throughout the State to increase affordable housing stock, including for adults with mental illness. The Mississippi Home Corporation is responsible for implementing the State's integrated permanent supported housing program. See House Bill No. 1563 (2015).

STATUTORY AND REGULATORY BACKGROUND

30. Congress enacted the ADA in 1990 "to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities[.]" 42 U.S.C. § 12101(b)(1). It found that "historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem[.]" 42 U.S.C. § 12101(a)(2). It further found that "discrimination against individuals with disabilities persists in . . . institutionalization . . . and access to public services[,]" 42 U.S.C. § 12101(a)(3), and that "individuals with disabilities continually encounter various forms of discrimination, including outright intentional exclusion . . . , segregation, and relegation to lesser services, programs, activities, benefits, jobs, or other opportunities[.]" 42 U.S.C. § 12101(a)(5).

31. Congress concluded that "the Nation's proper goals regarding individuals with disabilities are to assure equality of opportunity, full participation, independent living, and

economic self-sufficiency for such individuals" and "the continuing existence of unfair and unnecessary discrimination and prejudice denies people with disabilities the opportunity to compete on an equal basis and to pursue those opportunities for which our free society is justifiably famous, and costs the United States billions of dollars in unnecessary expenses resulting from dependency and nonproductivity." 42 U.S.C. § 12101(a)(7)-(8) (2008).

32. For those reasons, Congress prohibited discrimination against individuals with disabilities by public entities: "[N]o qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132.

33. Title II of the ADA prohibits discrimination on the basis of disability by public entities. This encompasses the State of Mississippi, its agencies, and its community mental health system, because a "public entity" includes any state or local government, as well as any department, agency, or other instrumentality of a state or local government, and it applies to all services, programs, and activities provided or made available by public entities, such as through contractual, licensing, or other arrangements. 42 U.S.C. § 12131(1) and § 12132.

34. Congress directed the Attorney General to issue regulations implementing Title II of the ADA. 42 U.S.C. § 12134. The Title II regulations require public entities to "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d). The preamble discussion explains that "the most integrated setting" is one that "enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible[.]" 28 C.F.R. pt. 35, App. B (2011).

35. Regulations implementing Title II of the ADA further prohibit public entities from utilizing "criteria or methods of administration" "[t]hat have the effect of subjecting qualified individuals with disabilities to discrimination" or "[t]hat have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the public entity's program with respect to individuals with disabilities[.]" 28 C.F.R. § 35.130(b)(3); accord 45 C.F.R. § 84.4(b)(4) (Rehabilitation Act).

36. In Olmstead, the Supreme Court affirmed that Title II prohibits the unjustified segregation of individuals with disabilities. The Court explained that its holding "reflects two evident judgments." 527 U.S. at 600. "First, institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life." Id. "Second, confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment." Id. at 601.

37. Under Olmstead, public entities are required to provide community-based services when (a) such services are appropriate, (b) the affected persons do not oppose community-based treatment, and (c) community-based services can be reasonably accommodated, taking into account the resources available to the entity and the needs of other persons with disabilities. Id. at 607.

38. CRIPA permits the United States to initiate action to vindicate the rights of individuals confined to psychiatric institutions, owned, operated, or managed by a State, who have been deprived of their statutory rights. See 42 U.S.C. § 1997.

FACTUAL ALLEGATIONS

A. State Hospitals are Segregated, Institutional Settings

39. Mississippi operates four costly, publicly-funded psychiatric hospitals located throughout the State: the Mississippi State Hospital, North Mississippi State Hospital, East Mississippi State Hospital, and South Mississippi State Hospital (collectively "the State Hospitals").

40. The State Hospitals are segregated, institutional settings that do not enable individuals living there to interact with non-disabled persons to the fullest extent possible. While confined in these institutions, individuals are deprived of meaningful opportunities, such as the opportunity to choose friends, participate in employment, or make choices about activities, food, or living arrangements.

41. Individuals residing in the State Hospitals live in close quarters with other persons with disabilities. They are assigned to small hospital rooms, often with roommates they did not choose.

42. The State Hospitals provide little opportunity for individuals with disabilities to interact with individuals without disabilities, apart from Hospital staff.

43. Individuals living in the State Hospitals have very little autonomy over their daily lives. Most aspects of their daily lives are regimented and limited by rigid rules and inflexible practices. These rules and practices include rights restrictions, structured meal times, limits on the ability to have visitors, and limits on travel outside the facilities. As a result, most aspects of their daily lives are controlled by the institutions, and they have little autonomy, privacy, or meaningful opportunities to participate in the community.

44. Physically, the State Hospitals are isolated from the general community—they are secluded on large tracts of land and cut off from towns, restaurants, stores, and public transportation, enjoyed by the broader community.

45. For instance, the Mississippi State Hospital, established in 1855 and originally known as the Mississippi State Lunatic Asylum, is located on a 350-acre campus in Whitfield, Mississippi, the site of a former state penal colony. The campus consists of over 130 buildings and has its own campus police department.

46. The Mississippi State Hospital employs approximately 1,750 employees.

47. The East Mississippi State Hospital, located in Meridian, employs approximately 1,130 employees. It was founded in 1882 and was originally known as the East Mississippi State Insane Asylum.

48. The North Mississippi State Hospital, located in Tupelo, and South Mississippi State Hospital, located in Purvis, were built recently. The North Mississippi State Hospital opened in 1999 and the South Mississippi State Hospital in 2000. Each of those hospitals employs over 100 full-time staff to cover its 50 beds.

B. Thousands of Mississippians Cycle in and out of State Hospitals Each Year

49. Thousands of adults with mental illness in Mississippi needlessly cycle in and out of the State Hospitals each year because they do not receive the supports they need in the community.

50. These individuals receive care in a hospital setting away from family, friends, and other natural supports, then return to their communities where they often get no or insufficient treatment, their symptoms get worse, they experience a crisis, and they return to the hospital.

51. Not including forensic beds, the State Hospitals have about 500 adult psychiatric beds. Collectively, they serve approximately 3,300 adults per year.

52. The average length of stay in the shorter-term units of the State Hospitals is 43 days.

53. Many individuals who are admitted to a State Hospital are first held at a local acute psychiatric hospital, crisis stabilization unit, jail, or holding facility while awaiting a placement at a State Hospital, lengthening the overall time spent in an institutional setting.

54. Repeat admissions to the shorter-term units of the State Hospitals are common.

55. For example, over 55% of the 206 adults in the shorter-term units at the Mississippi State Hospital on a randomly selected day in 2014 had previously been admitted two or more times, and more than 11% had previously been admitted more than ***ten*** times.

56. One twenty-seven year old man admitted to the Mississippi State Hospital on a randomly selected day in March 2015 had *22 prior admissions* to the Hospital. Individuals with persistent needs cycle through the State Hospitals over and over again, to say nothing of admissions to local emergency rooms, private psychiatric hospitals, and jails.

57. Readmissions typically result from insufficient services in the community and inadequate coordination between treating professionals in facilities and those who support the individuals when they are in the community.

58. The State often fails to ensure that there is a plan for providing services and supports in the community that will meet the individual's needs and prevent readmission to the State Hospitals. Community mental health centers are core providers supporting people with mental illness when they return to the community, yet they often are not involved in treatment and discharge planning. Other than scheduling a follow-up appointment for the individual at the local provider, there is typically minimal coordination between the State Hospital and the local provider.

C. Individuals in the Mississippi State Hospital's Longer-Term Units Remain There for Years

59. Over 100 individuals were institutionalized in the Mississippi State Hospital longer-term units in fiscal year 2014.

60. The average length of stay that year for individuals in the Mississippi State Hospital longer-term units was over seven years. One individual was admitted to the Mississippi State Hospital in 1959, at the age of twenty, and remained there over fifty years, at least until 2015.

61. Individuals dually-diagnosed with mental illness and an intellectual or developmental disability may spend years in a State Hospital due to the lack of community-based services to meet their needs.

62. While the State has reduced the number of longer-term beds at the State Hospitals, it has simultaneously transferred many individuals to other long-term, segregated settings, including other State-run facilities, nursing facilities, and personal care homes. It has also discharged individuals from the State Hospitals to homelessness and other unstable environments.

63. Some of the individuals who had been institutionalized at the Mississippi State Hospital have been placed in a nursing facility on the same grounds as a State Hospital.

64. Other individuals were discharged to the Central Mississippi Residential Center, a State-funded residential behavioral health program for adults with mental illness that looks much like the State Hospitals. The Center consists of multiple buildings on an isolated campus in Newton, Mississippi with a capacity to serve 68 individuals at a given time. The average length of stay at the Center is 545 days; however, several individuals have lived at the Center for five years or more, many of whom already spent much of their lives in a State Hospital.

65. Mississippi's State Hospitals fail to offer appropriate treatment and discharge planning necessary to successfully transition individuals to the community. Discharge plans are

frequently boilerplate and disconnected from the skills individuals need in order to live in the community.

D. Mississippi's Administration of its Service System has Caused Unnecessary Segregation of Individuals in State Hospitals and Placed Others at Serious Risk of Unnecessary Institutionalization

66. Through the Mississippi Division of Medicaid and Department of Mental Health, the State determines what services will be provided, where services will be available, how services will be funded, who will be eligible for services, how service quality will be evaluated, and what providers are permitted to offer the services.

67. The Mississippi Department of Mental Health funds and operates the State Hospitals.

68. The Mississippi Department of Mental Health and Division of Medicaid plan, contract, fund, regulate, and oversee the community mental health system that provides community-based alternatives to the State Hospitals.

69. The State offers community-based mental health services primarily through fourteen regional community mental health centers ("CMHCs"). The CMHCs are the principal service providers with whom the Mississippi Department of Mental Health and Division of Medicaid contract to furnish a range of community-based mental health and substance abuse services to persons with disabilities, including mental illness. The Mississippi Department of Mental Health is responsible for certifying, monitoring, and assisting the CMHCs.

70. The CMHCs are required to offer certain mental health services, including psychiatric services, individual and group therapy, community-based support services, crisis services, and peer support services. Some CMHCs also offer more intensive services, like Assertive Community Treatment, supported employment, and residential services. In addition, the

Department of Mental Health pays the CMHCs to conduct pre-screening evaluations to determine whether individuals are eligible for admission to a State Hospital.

71. The Mississippi Department of Mental Health and Division of Medicaid exercise control over the availability and quality of community mental health services in the State.

72. The Mississippi Department of Mental Health certifies each CMHC prior to its selection as the designated provider, promulgates operational standards for all CMHCs, conducts reviews of CMHC operations, awards grant funds to support specific community services, and requires financial and performance reporting.

73. The Mississippi Division of Medicaid establishes the Medicaid services that will be available, defines the purpose of those services, defines limits on those services, engages in utilization control, and determines the rates for those services.

74. Numerous policies, practices, and actions by the State, including the Mississippi Department of Mental Health and Division of Medicaid, have led to the unnecessary segregation of individuals with mental illness in State Hospitals and placed many other individuals with mental illness at serious risk of institutionalization. Despite being aware that it unnecessarily relies on an institutional model to serve individuals with mental illness, the State continues to discriminate against people with mental illness by failing to provide sufficient, integrated community-based mental health services consistent with their individual needs. It has done so primarily by: (1) failing to provide sufficient community-based mental health services throughout the State and (2) concentrating funding in its State Hospitals rather than community-based services.

i. <u>The State fails to provide sufficient community-based mental health services throughout the State.</u>

75. The State recognizes that community-based services, including psychiatric services, individual and group therapy, intensive case management, crisis services, peer support services, Assertive Community Treatment, supported employment, and permanent supported housing promote positive outcomes and prevent hospitalizations among persons with serious mental illness. See, e.g., Mississippi Department of Mental Health, Think Recovery Newsletter 1, 6-7 (2015), *available at* http://www.dmh.ms.gov/wp-content/uploads/2015/09/MS-Recovery-Newsletter-Summer-2015.pdf (last visited January 13, 2016). Individuals with mental illness living in the community may need one or more of these community-based services at any given time to avoid unnecessary hospitalization. Yet the State fails to sufficiently provide community-based mental health services, particularly in certain geographic areas of the State, leaving thousands of people who are in the State Hospitals or at serious risk of entering those Hospitals without the ability to access needed community-based treatment.

76. In fiscal year 2015, nearly 5,500 individuals were screened for non-forensic admission and about 3,300 were ultimately placed in a State Hospital. More individuals could be diverted from costly, segregated institutional placement at the State Hospitals if the State increased the availability of community-based services.

77. Crisis services are a critical part of a successful community mental health system because effective crisis professionals can divert individuals from institutionalization and link them quickly to needed community-based services. For instance, mental health clinicians offering mobile crisis services go into the community to meet individuals at the site of a crisis and offer interventions to prevent hospitalization. Crisis professionals can also work closely with law enforcement to help divert individuals from arrest and incarceration or civil commitment.

78. The State acknowledges that "[w]ithout mobile crisis intervention, someone experiencing a mental health crisis may end up in a hospital, inpatient psychiatric program, a holding facility or even a jail." Mississippi Department of Mental Health, Mississippi Profile 9 (2015), *available at* http://www.dmh.ms.gov/wp-content/uploads/2015/03/Mississippi-Profile-Winter-and-Spring-2015.pdf (last visited January 13, 2016).

79. The State, however, is not ensuring that these critical face-to-face interventions are uniformly available to individuals in crisis across the State. While one CMHC reported over 3,000 face-to-face mobile crisis interventions in fiscal year 2015, another CMHC, with a nearly identical regional population, reported fewer than 50 face-to-face interventions all year.

80. Assertive Community Treatment ("ACT") is another critical community-based mental health service that is not sufficiently available in Mississippi. It is an intensive team-based treatment model that provides multidisciplinary, flexible treatment and support to people with mental illness to increase integration and prevent hospitalizations. Substance Abuse and Mental Health Services Administration, Assertive Community Treatment: Building Your Program 5, Pub. No. SMA08-4344 (2008).

81. The State recognizes the importance of ACT in helping individuals with serious mental illness remain stable in the community and avoid unnecessary institutionalization. A Mississippi Department of Mental Health press release about the State's ACT program stated, "[i]n the four years DMH has had [ACT] teams operating, they have been extraordinarily successful in helping individuals in recovery by ensuring they can stay and participate in the communities of their choice." Further elaborating on the success of the program, the Department of Mental Health Executive Director, Diana Mikula, stated, "Recovery not only benefits the individual, it benefits the entire community. . . . Evidence-based programs such as [ACT] Teams are essential to keep

individuals in the community and help them continue on their road to recovery." Mississippi Department of Mental Health, Mississippi Expands Program of Assertive Community Treatment Teams, *available at* http://www.dmh.ms.gov/mississippi-expands-program-of-assertive-community-treatment-teams/ (last visited January 13, 2016).

82. In spite of this recognition, the State only offers ACT services in about half of its fourteen community mental health regions statewide, and the existing teams serve a very small number of individuals.

83. In fiscal year 2015, the State served only 189 people with ACT through its eight ACT teams, despite the overwhelming need for the service.

84. ACT teams are designed to serve between 80 and 100 individuals each, so the existing teams could serve between 640 and 800 individuals while implementing the service with fidelity to the evidence-based model. Due to poor implementation of the service, the teams remain underutilized.

85. The absence of ACT capacity is particularly palpable in the Jackson area. Hinds and Rankin counties, covering the Jackson metropolitan area, send more people to State Hospitals for treatment than any other counties in Mississippi; in fiscal year 2015, 307 people from Hinds County and 206 people from Rankin County were served in the State Hospitals. Together, the two counties account for about 17% of the people served in the State Hospitals, yet neither county had an ACT team until 2015.

86. An ACT team was established in Hinds County in 2015, but because it only served 17 individuals, it had little impact on reducing the number of State Hospital admissions. No ACT team serves Rankin County.

87. The State has begun to establish a certified peer support program through which individuals who have lived with mental illness assist others with mental illness to increase resiliency, manage symptoms, build community living skills, and work toward recovery in order to live integrated lives in the community and avoid hospitalization. The State recognizes that peer support can be just as valuable as other professional treatment services for people with mental illness. See Mississippi Department of Mental Health, Think Recovery Newsletter 1 (2015), *available at* http://www.dmh.ms.gov/wp-content/uploads/2015/09/MS-Recovery-Newsletter-Summer-2015.pdf (last visited January 14, 2016).

88. Peer support services are not sufficiently available throughout the State, however. In fact, two of the CMHC regions each employ only a single peer support specialist. Over 450,000 people live in the 14 counties served by those CMHCs.

89. Permanent supported housing is another service that enables people with serious mental illness to avoid hospitalization. As its name implies, permanent supported housing is (1) permanent, meaning "tenants may live in their homes as long as they meet the basic obligations of tenancy[;]" (2) supportive, meaning "tenants have access to the support services that they need and want to retain housing;" and (3) housing, meaning "tenants have a private and secure place to make their home, just like other members of the community, with the same rights and responsibilities." Substance Abuse and Mental Health Services Administration, Permanent Supportive Housing: Building Your Program 1, Pub. No. SMA-10-4509 (2010).

90. The State has recognized the need for permanent supported housing as an effective evidence-based service for individuals with serious mental illness that enables people to live integrated lives in the community and avoid institutionalization. See Technical Assistance

Collaborative, A Statewide Approach for Integrated Supportive Housing in Mississippi 1-3 (2014); House Bill No. 1563 (2015).

91. The State acknowledges, however, that sufficient permanent supported housing is not available in Mississippi to meet the needs of persons with mental illness. The State calculates that over 7,000 people are candidates for permanent supported housing, and that it would need to provide at least 2,900 slots to meet the national rate of permanent supported housing availability. Still, the State has provided funding for what they estimate will support only 200 permanent supported housing slots for fiscal years 2015 and 2016. See House Bill No. 1563 (2015).

92. The insufficiency of community services coupled with inadequate State Hospital discharge planning places people at serious risk of readmission to a State Hospital. Individuals are frequently discharged from a State Hospital without sufficient community supports in place and to inappropriate housing, such as homeless shelters. For instance, in fiscal year 2014, at least 56 individuals were discharged to homelessness.

93. Mississippi's failure to develop a sufficient, high-quality supply of community-based services and failure to conduct adequate discharge planning from its State Hospitals to the community forces individuals with mental illness to obtain necessary services at inappropriate and costly venues, such as emergency rooms, jails, and psychiatric hospitals.

ii. The State fails to fund sufficient community-based services and instead focuses funding on institutional settings.

94. The State's reliance on institutional care is reflected in its spending.

95. In spite of a challenging fiscal environment, the State has continued to concentrate funding on costly institutional care at State facilities when it could provide appropriate, less

expensive services in the community and share the cost of many of those services with the federal government.

96. Virtually all of the costs of the State facilities are paid for with State general funds. When the State provides community alternatives through its Medicaid program, however, the federal government provides matching funds; the federal government pays for 73% of all Medicaid expenditures in Mississippi. Federal Medicaid dollars are not available to fund inpatient psychiatric services for adults under 65 in the State Hospitals, but would be available to all Medicaid beneficiaries receiving eligible community-based services.

97. In fiscal year 2015, the Mississippi Department of Mental Health spent $202.5 million on the State Hospitals. In addition to the State Hospitals, the State has concentrated resources in its 68-bed Central Mississippi Residential Center. In fiscal year 2015, the State spent $5.8 million to operate the Center.

98. The State reports that the cost for one individual in the State Hospitals is over $470 per day, on average. Based on the CMHC Billing Guidelines, the approximate cost to the State (minus the federal portion) to serve Medicaid eligible individuals with the most intensive needs who instead receive ACT in the community is approximately $30 per day. And many individuals served at the State Hospitals will not need the most intensive and most expensive community-based services in order to avoid unnecessary hospitalizations.

99. The Mississippi Legislature's Joint Committee on Performance Evaluation and Expenditure Review committee reported in 2008 that, generally, institution-based services cost more per client than community-based services and that the State's focus on institution-based care "represents a much more expensive service delivery model than does community-based

care." Joint Legislative Committee on PEER, Report to the Miss. Legislature No. 511, Planning for the Delivery of Mental Health Services in Mississippi: A Policy Analysis 55 (2008).

100. The State's recent spending on new facilities at the East Mississippi State Hospital is another example of its significant investment in the State Hospitals. In the last two years, the State has funded several new buildings at East Mississippi State Hospital, with the newest ones currently under construction. In 2014, the State opened a new $7 million dining facility. The State is currently spending $14 million to build a brand-new 60-bed unit and a central mechanical building.

101. Even though the State modified its Medicaid State Plan in 2012 to make some critical community-based mental health services Medicaid reimbursable, including mobile crisis, ACT, and peer support, these services are still not being offered in sufficient quantity. For instance, in fiscal year 2014, Medicaid only reimbursed providers for serving 60 people with ACT and 533 people with peer support. Yet offering these Medicaid reimbursable services makes economic sense given the federal government's matching funds.

102. Mississippi could serve individuals with mental illness in the community by maximizing existing resources—both by redirecting spending from segregated, institutional settings to community-based programs and by fully implementing the State's Medicaid State Plan services.

E. Mississippi is Aware That it Unnecessarily Relies on Institutional Settings and has not Taken the Action Needed to Remedy the Violations of Law

103. The State has long been aware of the failures of its mental health system. In recent years, Mississippi has recognized, and reported on, the State's significant reliance on institutional care to serve persons with disabilities, including mental illness.

104. In 2008, the Mississippi Legislature's PEER Committee issued a comprehensive report that concluded that the Board of Mental Health had not focused on developing adequate community-based programs and reallocating resources to meet the emergent needs of persons with mental illness in Mississippi. Joint Legislative Committee on PEER, Report to the Miss. Legislature No. 511, Planning for the Delivery of Mental Health Services in Mississippi: A Policy Analysis 54-56 (2008). The PEER committee concluded that Mississippi was out-of-step with national trends and was failing to meet the needs of persons with disabilities in integrated community settings. Id. at 1 ("Although the mental health environment in the United States has dramatically changed from an institution-based system to a community-based system in recent years, Mississippi's mental health system has not reflected the shift in service delivery methods.").

105. The PEER committee recognized that, due to the ADA and the Olmstead decision, "the state will be forced to move toward providing more community-based care in the near future." Id. The PEER committee concluded that the State was not in a good position to address outstanding issues because the Mississippi Board of Mental Health "has not aggressively sought plans for reallocation of resources to meet emerging needs in addition to efforts to seek additional funding to meet those needs . . . [thus,] allowing the development of community-oriented programs to fall behind." Id.

106. In June 2014, the PEER committee again found that the State has missed opportunities to provide community-based services. In a report related to the closure of the Mississippi State Hospital's Community Services Division, the PEER committee noted that the Department of Mental Health redirected resources from the closure of community-based programs into the State Hospitals, thus "forgo[ing] the opportunity to redirect the resources yielded from closure of the

[community services] division into providing community-based mental health care." Joint Legislative Committee on PEER, Report to the Miss. Legislature No. 584, A Review of the Closure of the Mississippi State Hospital's Community Services Division viii (2014).

107. In a May 2015 report, the PEER committee again reiterated that "Mississippi will be forced to move toward providing more community-based mental health care in the near future" and recommended that "[t]he Department of Mental Health and Mississippi State Hospital should gather the appropriate data sets regarding the mental health needs of the hospital, the communities, and the state in order for the department to articulate its community-based services strategy, design its implementation process, and reallocate its resources." Joint Legislative Committee on PEER, Report to the Miss. Legislature No. 593, Staffing of Psychologists at the Mississippi State Hospital in a Changing Mental Health Service Delivery Environment 1 (2015).

108. As early as 2001, the State acknowledged the need for significant change in its Olmstead Plan. The Olmstead Plan, developed in conjunction with various stakeholders, was entitled Mississippi Access to Care ("MAC"), and was submitted to the Mississippi Legislature on September 30, 2001. Mississippi Access to Care Plan (2001), *available at* https://www.medicaid.ms.gov/wp-content/uploads/2013/12/MAC_2001Plan.pdf (last visited January 14, 2016). The overall stated purpose of the Plan was to "create an individualized service and support system that enables individuals with disabilities to live and work in the most integrated setting of their choice. It is our vision that all Mississippians with disabilities will have the services and supports necessary to live in the most appropriate and integrated setting possible." Id. at 9.

109. Among the many changes that the Plan identified as necessary to realize this vision were the development of community housing alternatives for over 1,000 adults with serious mental

illness, the expansion of the State's supported employment program, and the expansion of intensive case management. Id. at 22, 28, 39.

110. The first and only implementation report explained that while some agencies were attempting to implement the reforms identified in the State's Olmstead Plan, the State had not funded the Plan and this made full implementation impossible. MAC Implementation Report #1 5 (2003).

111. After ten years in which the State did not engage in any meaningful Olmstead planning, the State launched MAC 2.0 in 2013. MAC 2.0 is apparently an umbrella for workgroups related to specific federal grant programs.

112. This MAC 2.0 initiative has not resulted in a revised Olmstead Plan. See Mississippi Division of Medicaid, Mississippi Access to Care (MAC) 2.0, *available at* https://www.medicaid.ms.gov/mississippi-access-to-care-mac-2-0/ (last visited January 14, 2016).

113. The Department of Mental Health's current strategic plan also recognizes that expansion of community-based services and supports is critical. The strategic plan is aimed at "moving toward a community-based service system." Mississippi Board of Mental Health, FY16-FY18 DMH Strategic Plan 1.

114. The goals in the current plan highlight the continued need for reform. The plan calls for providing supports in the community "to prevent out-of-home placements[;]" ensuring access to crisis services to "divert individuals from more restrictive environments such as jail, hospitalizations, etc.[;]" providing adults with serious mental illness access to "appropriate and affordable housing[;]" and using peer support to "assist individuals in regaining control of their lives and their own recovery process[.]" Id. at 8.

115. Nearly fifteen years after developing the State's Olmstead Plan, the State still is not meeting its obligations under the ADA to serve adults with serious mental illness in the most integrated setting appropriate.

F. Individuals with Mental Illness in State Hospitals Or at Serious Risk of Hospitalization are Persons with Disabilities Who are Qualified to Receive Services in More Integrated Settings and Do Not Oppose It

116. Individuals admitted to or at serious risk of entry into State Hospitals have mental illnesses, such as schizophrenia, bipolar disorder, depression, and others, that substantially limit one or more major life activities, including personal care, working, concentrating, thinking, and sleeping. They are therefore persons with disabilities for purposes of the ADA.

117. A vast majority of the individuals with mental illness in the State Hospitals and those at serious risk of entry into those hospitals are qualified to receive mental health services in the community and can be served in more integrated settings.

118. People in the State Hospitals and those at serious risk of entry into those hospitals are similar to people with mental illness who receive services in the community. They have similar diagnoses and needs as people who live successfully in more independent community-based settings with the types of supports and services that currently exist in the State's community mental health system.

119. Persons with mental illness at the State Hospitals would not oppose moving to and receiving services in integrated settings if appropriate community-based services were available and if individuals had a realistic opportunity to do so.

120. Individuals in the State Hospitals routinely request to leave the facility and return to their own communities.

G. The State Can Provide Services in Integrated Settings by Reasonably Modifying Its Mental Health Services System

121. The State can provide services in integrated community settings to people with mental illness who are currently held in State Hospitals and to people with mental illness at serious risk of entry into State Hospitals through reasonable modifications to its mental health services system.

122. The types of services needed to support people with mental illness in community-based settings already exist in Mississippi's community-based mental health service system.

123. However, these services are not sufficiently provided to meet the needs of persons who are unnecessarily institutionalized or those at serious risk of institutionalization.

124. With reasonable modifications, including expansion of the capacity to provide existing services, reallocation of funds from institutions, and maximization of the State's Medicaid program, Mississippi's community mental health system would be able to meet the needs of people with mental illness in State Hospitals or at serious risk of being placed in a State Hospital.

H. The United States' Investigation

125. After receiving an allegation of discrimination, in 2011, the United States investigated the State of Mississippi's compliance with Title II of the ADA. On December 22, 2011, the United States issued its findings and conclusions in a letter to the Governor, concluding that the State fails to provide services to adults with mental illness in the most integrated setting appropriate to their needs as required by the ADA and Olmstead. Letter from United States Department of Justice, Civil Rights Division to The Honorable Haley R. Barbour (Dec. 22, 2011).[1] The letter

[1] The United States also made findings related to children with serious mental health conditions and adults and children with intellectual and/or developmental disabilities. This Complaint does not address the United States' claims with regard to these other populations.

reported in detail the findings of the United States' investigation, provided the State notice of its failure to comply with the ADA, and outlined the steps necessary for the State to meet its obligations pursuant to federal law.

126. Nonetheless, the State continues to fail to ensure that adults with mental illness are served in the most integrated setting appropriate to their needs, or that their discharge planning needs are met in order to transition successfully into community settings.

127. The United States engaged in multiple rounds of negotiations with the State beginning in the spring of 2012. The United States has determined that compliance cannot be secured by voluntary means. Judicial action is, therefore, necessary to remedy the violations of law identified in the United States' letter and to vindicate the rights of the adults with mental illness in or at serious risk of institutionalization in State Hospitals.

COUNT I

VIOLATION OF TITLE II OF THE AMERICANS WITH DISABILITIES ACT

42 U.S.C. §§ 12131 et seq.

128. The allegations of Paragraphs 1 through 127 of this Complaint are hereby realleged and incorporated by reference.

129. Defendant, State of Mississippi, is a public entity subject to Title II of the ADA, 42 U.S.C. § 12131(1).

130. The State violates the ADA by administering the State's mental health service system in a manner that denies qualified adults with mental illness the benefits of the State's mental health services, programs, or activities in the most integrated setting appropriate to their needs and by

failing to reasonably modify the State's mental health services system to avoid discrimination against adults with mental health disabilities. 42 U.S.C. § 12132; 28 C.F.R. 35.130.

131. The State's actions constitute discrimination in violation of Title II of the ADA, 42 U.S.C. § 12132, and its implementing regulations at 28 C.F.R. pt. 35.

132. The acts and omissions alleged in Paragraphs 1 through 127 constitute a pattern or practice and infringe upon the legal rights of individuals residing in or confined to institutions in Mississippi, constituting resistance to their full enjoyment of their rights, privileges, or immunities secured or protected by the ADA, and depriving persons in institutions of such rights, privileges, or immunities.

PRAYER FOR RELIEF

The Attorney General is authorized under 42 U.S.C. §§ 1997 and 12131 et. seq. to seek equitable and declaratory relief.

WHEREFORE, the United States of America prays that the Court:

A. Grant judgment in favor of the United States on its Complaint and declare that the Defendant has violated Title II of the ADA, 42 U.S.C. §§ 12131 et. seq.;

B. Enjoin Defendant from:

1. discriminating against adults with mental illness in Mississippi by failing to provide services, programs, or activities in the most integrated setting appropriate to their needs;

2. failing to provide appropriate, integrated community services, programs, or activities to adults with mental illness in Mississippi, consistent with their individual needs, to

avoid placing these individuals at serious risk of institutionalization in State Hospitals; and

3. taking appropriate action necessary to remedy the violation of Title II of the ADA.

C. Issue a declaratory judgment that Defendant has violated Title II of the ADA by failing to make reasonable modifications to services, programs, or activities for adults with mental illness to enable them to obtain the services, programs, and activities they require to reside in the most integrated setting appropriate to their needs;

D. Order such other appropriate relief as the interests of justice may require.

This 11th day of August, 2016

Respectfully submitted,

FOR THE UNITED STATES:

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CERTIFICATE OF THE ATTORNEY GENERAL

I, Loretta E. Lynch, Attorney General of the United States, certify that with regard to the foregoing Complaint, United States v. State of Mississippi, I have complied with all subsections of 42 U.S.C. § 1997b(a)(1). I certify as well that I have complied with all subsections of 42 U.S.C. § 1997b(a)(2). I further certify, pursuant to 42 U.S.C. 1997b(a)(3), my belief that this action by the United States is of general public importance and will materially further the vindication of rights, privileges, or immunities secured or protected by laws of the United States.

In addition, I certify that I have the "reasonable cause to believe," set forth in 42 U.S.C. § 1997a, to initiate this action, and that all prerequisites to the initiation of this suit under 42 U.S.C. §§ 1997a and 1997b have been met.

Pursuant to 42 U.S.C. § 1997a(c), I have personally signed the foregoing Complaint. Pursuant to 42 U.S.C. § 1997b(b), I am personally signing this Certificate.

Signed this 4th day of August, 2016, at Washington, D.C.

Loretta E. Lynch

LORETTA E. LYNCH
Attorney General of the United States

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Association of Mississippi Peer Support Specialists Announces Executive Board

Mississippians in recovery are pleased to announce the formation of the Association of Mississippi Peer Support Specialists, a network of individuals in recovery from mental illness and substance use disorder whose mission is to empower Peer Support Specialists, and to advance Peer Support in Mississippi.

In the summer of 2014, a group of peer support specialists in Mississippi volunteered to form a planning committee to create a state-wide, peer-run network. Their vision is to be a source of inspiration, empowerment, and encouragement to peer supporters of all mental health conditions throughout the state. The Association of Mississippi Peer Support Specialists (AMPSS) was officially incorporated by the state this June.

The Department of Mental Health had previously assisted in a Certified Peer Support Network, but a grant from the Substance Abuse and Mental Health Services Administration allowed peer specialists around the state to transform that network into the AMPSS, a peer-led organization.

The AMPSS is pleased to announce its inaugural Executive Board: Chair Stephanie Stout, Lifecore Health Group; Vice Chair Curtis Oliver, FAVOR MS Recovery Advocacy Project; Secretary Melody Worsham, Mental Health Association of South Mississippi; and Treasurer Jess Whatley, Southwest Mississippi Mental Health Complex.

What is Peer Support and what is a Certified Peer Support Specialist?

Peer Support is getting help from someone who has been there. People with similar experiences may be able to listen, give hope and guidance toward recovery in a way that is different, and may be just as valuable, as professional services.

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Upcoming Events

Next Certified Peer Support Professional Training:
Oct. 13-16, Summit, MS
Visit www.dmh.ms.gov for more info

Annual Trauma Conference:
Facing the Storm:
From Basic to Practice
Jackson Convention Center
9/16—9/18/15
Register Now!

To submit information or article ideas for the Think Recovery newsletter, contact Adam Moore at Adam.moore@dmh.state.ms.us or DMH's Division of Recovery and Resiliency at 601.359.1288.

A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Supporting a Better Tomorrow...Today
DMH
Mississippi Department of Mental Health

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Peer services include mutual support groups, peer-run programs and services in traditional mental health agencies provided by peer support specialists. While peer support groups may be composed entirely of people who have simply learned through their own experiences, some types of peer providers undergo training and certification to qualify. In addition to direct services, many peer-run organizations, such as the National Alliance on Mental Illness, advocate to improve opportunities for people recovering from mental illnesses.

A Certified Peer Support Specialist (CPSS) is a family members and/or individual who has self-identified as having received or is presently receiving behavioral health services. Additionally, a CPSS has successfully completed formal training recognized by the Mississippi Department of Mental Health (DMH) and is employed by a DMH Certified Provider.

To learn more or how to become a CPSS, review the DMH web page at www.dmh.ms.gov/peer-support-services, or contact us at 601.359.1288.

CPSS Renewal Deadline is September 30, 2015

This year is the first renewal of the DMH Certified Peer Support Professional Program. The deadline for CPSS renewal is September 30, 2015 at 5 p.m.

If you have not received the renewal applications or directions, please contact Sherry Bouldin or Aurora Baugh at 601.359.1288. If you have received the application, please make sure to read the directions thoroughly and complete the application in its entirety. Remember that renewal applications must be signed in blue ink.

If you have not completed all of the required 20 CEU hours, Relias Learning courses are available online. Please see your Staff Development Officer or Human Resources for access to the Relias Learning System. Proof of CEUs is not required to be submitted at the time of renewal. You may be randomly selected for audit and required to submit proof at a later time. Read the directions for proration scale.

Renewed individuals and Staff Development Officers will be sent renewal confirmations, along with renewal documents, to the self-reported email addresses.

The staff of the Division of Recovery and Resiliency is always available to answer any questions or concerns you may have. Feel free to contact us at 601-359-1288. In addition, all of the renewal documents are available at www.dmh.ms.gov. To access them, click on the What We Believe tab, click Peer Support Services and then click Documents.

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22 Graduate from Mississippi Leadership Academy

Twenty-two individuals graduated from the 2015 class of the Mississippi Leadership Academy on May 24, 2015 at the Gray Conference Center near Canton.

The Mississippi Leadership Academy (MLA) is an opportunity for people receiving mental health services to build their leadership skills and to become effective members of teams who plan and develop mental health services in Mississippi.

The Mississippi Leadership Academy fits well into the person-centered, recovery-oriented system of care that Mississippi's public mental health system now fosters on a daily basis. The ultimate goal of MLA is to enable individuals to be more effective contributors to the decision process when they serve on mental health boards, task forces, and committees. This program is sponsored by the Mississippi Department of Mental Health and has produced more than 176 graduates since 2005.

All twenty-two graduates of the 2015 class are successfully managing their recovery and are now trained and ready to assist others as mentors or as participants on the regional and/or state mental health committees.

This year's participants represented regions state wide. Some of the lessons included how to be an effective team member, cultural diversity, project planning, and participating in the work environment.

The Mississippi Leadership Academy is designed to be taught in three consecutive days. It is offered periodically and is free to participants who are accepted in the program. For future MLA training opportunities, visit the Department of Mental Health website.

Congratulations to the newest graduates of the Mississippi Leadership Academy. ◆

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Elerie Crawley *Recovery Story*

We all want to think we're okay. When you go through your life thinking you just had a "bad hair day" you push through to be as normal as possible. When it becomes clear you have been living with a debilitating mental illness all your life, you realize that something has been wrong all along, and not only must you push through it, but you must learn to live with it. This is my story.

I was raped at the tender age of three, which taught me secrecy, mistrust, and pain tolerance. If I acted up, I didn't know it, but often found myself running away from situations in order not to be punished. Closets were my best friends. No one asked and the abuse continued. I'd wet myself on the floor at home and in the most embarrassing places, such as the school classroom. This taught me humiliation and despair. I stuttered and went to speech classes. This taught me English. I was promiscuous as a teenager for want of attention, and finally became pregnant and was forced to marry someone who didn't want to be married, let alone have children. After 10 years of acting up when angry spurts arose over jealous trifles of infidelity, I learned hate and remorse. The next ten years of single parenting started shedding light that something was wrong, but I would self-medicate to fix the outbursts and depression. I learned loneliness and poverty.

I went into the music business, a great place for those like me, where everyone could act up and get away with it and everyone was crazy. But it was in the business that I met a man who actually cared about me. I learned love. This wonderful human being saw something in me that I had never seen; not only did he teach me love but he taught me respect for myself and others. He taught me spirituality and gave me the encouragement to go on and be strong. I continued to act up, mostly by getting drunk and starting a fight, but he remained and continued to love me and married me.

My determined, self-driven motivation has pulled me through the roughest times of my life to reach the position as Ambassador and Certified Peer Support Specialist.

After a few years, on a balmy summer evening after a bout with a sibling, I walked (which I often did after stating my piece of mind) and I walked and I walked. The next morning the sibling found me and I knew then I had hurt another. I needed help; I was already 55 years of age.

I sought help with a medical doctor who immediately

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saw my symptoms and declared I was bipolar. I was referred to a specialist who confirmed the diagnosis as bipolar and borderline personality disorder. Medication was prescribed and my journey began to finally live.
Now, five years later, I am one of the chosen Ambassadors representing the Certified Peer Support Specialists in the state of Mississippi. Moreover – and this has been advantageous, not a detriment – I am in recovery from bipolar disease and borderline personality disorder.

My determined, self-driven motivation has pulled me through the roughest times of my life to reach the position as Ambassador and Certified Peer Support Specialist. I am currently working for a community center in North Mississippi educating peers in recovery action plans, helping other individuals to recover. I am also involved with the Department of Mental Health Personal Outcome Measures. I am a member of NAMI (National Alliance of Mental Illness) as well as a facilitator for NAMI Peer to Peer.

I live with my husband and cat, "Pup." These responsibilities have been the key factors in my life and growth. I am very active spiritually; Jehovah God is the primary source of encouragement during my recovery. In my pastime, I like to read, write books, am a graphics designer and enjoy gardening. I've learned to help others and I've learned to live.

- *Elerie Crawley*, CPSS

Mental Health Month Recognized in May

Mississippians joined thousands of others across the country as they recognized May as Mental Health Month, a tradition started by Mental Health America in 1949.

"The month-long recognition stands as a reminder that mental health concerns are no different from physical health concerns," said Diana Mikula, Executive Director of the Mississippi Department of Mental Health. "People should feel free to talk about their mental health, encouraged to seek treatment when it is needed and to be free from judgement regardless of their health conditions."

About half of Americans will meet the criteria for a diagnosable mental health disorder sometime in their life, with first onset usually in childhood or adolescence. Research shows that by ignoring mental health symptoms, someone could lose up to ten years of his or her life during which intervention could be successful. During most of these years, most people still have supports that allow them to succeed —home, family, friends, school, and work. Intervening effectively during early stages of mental illness can save lives and change trajectories in the lives of individuals living with mental illnesses.

Over the past year, the Mississippi Department of Mental Health (DMH) has sought to share stories of recovery from individuals who have been living with mental illness, using their own words to show others that recovery is possible and someone can live a happy, productive life despite a diagnosis of mental illness.

Many of these personal stories, from written words to video testimonials, can be found on the Recovery page of the DMH web site at http://www.dmh.ms.gov/think-recovery/.

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"My journey began in the summer of 1977 just before my senior year of high school," says David Connell, of Greenwood, in one video. "Later I was told that I had schizophrenia, which scared me, and I tried very hard to keep it a secret. Graduating from high school is supposed to be a springboard to better days ahead, but I felt like my life had crashed and burned."

Connell goes on to share how he went on to college, but experienced difficulties with his illness and with the side effects of his medication. He worked through that to graduate, but his illness continued causing problems in life.

"My self-esteem was so low that I had a hard time holding a job, so during this time I began to save my money while I was working, because struggling with a mental illness, I never knew what would come my way," he said.

He had ups and downs over the years, before finally accepting his diagnosis and its place in his life. He now serves as chairman of the Mississippi State Mental Health Planning and Advisory Council.

"The final breakthrough began about two years ago, during a crisis period, when I finally decided to quit trying to keep my illness a secret from the world and accept myself as having something to contribute to others," he said. "That was probably one of the best steps I ever took. It removed a tremendous amount of stress from me and my family.

> *Knowing that people believe in me enough to ask me to be a part of a team that pursues the bigger picture in the mental health world offers me hope and a bright future.*
> *~ Amanda Clement*

"What does recovery mean to me? It means being able to make a meaningful contribution."

The Mississippi Department of Mental Health has significantly expanded the availability of community-based services in order to help other Mississippians reach a place where they can make meaningful contributions as well, whether those contributions are to their own lives, to their families or to their broader communities as a whole.

Mobile Crisis Response Teams (MCeRT), Programs of Assertive Community Treatment (PACT) Teams and Crisis Intervention Teams (CIT) are three of the ways DMH is expanding community services. All three of these programs are multidisciplinary teams focused on bringing services to the locations where individuals need them.

MCeRTs are available throughout Mississippi and are operated by the regional Community Mental Health Centers. They can respond to a behavioral health crisis in any location. Many have agreements with their local hospitals, and are providing some training to the nursing and medical staff members there on how to handle a behavioral health crisis. They can also be called in to deal with those mental health emergencies that do come into a hospital, freeing up the medical staff to handle the other emergencies that commonly come into emergency rooms.

The concept of a PACT team is a person-centered, recovery-oriented mental health service delivery model for facilitating community living, psychological rehabilitation and recovery for persons who have the most severe and persistent mental illnesses and have not benefited from traditional outpatient services.

They are also mobile, delivering services to individuals in their homes and communities. This evidence-based program enables people to remain in their communities and avoid placement in an inpatient environment. PACT teams are currently available through the

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regional Community Mental Health Centers in DeSoto, Forrest, Lamar, Hancock, Harrison, Jackson, Hinds, Leflore, Grenada, Holmes, Warren and Yazoo Counties.

Crisis Intervention Teams are partnerships between law enforcement officers and local health providers. Officers who have received crisis intervention training respond to individuals experiencing a mental health crisis and divert them to an appropriate setting to provide treatment, ensuring individuals are not arrested and taken to jail due to the symptoms of their illness. Through a federal grant, DMH is able to offer this training for the next three years at no cost for up to 40 officers per year throughout Mississippi.

Community-based programs such as these are enabling individuals with a diagnosis of mental illness to experience their own journeys of recovery, and to share that experience with others. Amanda Clement said being involved in the community has given her hope. She said she has come a long way, going from some dark days to successes, hopes and dreams.

She has had the opportunity to volunteer at hospitals, has been involved in the National Alliance on Mental Illness's "In Our Own Voice" program and has spoken at Department of Mental Health programs. All of those opportunities have proved to help her self-esteem and have been very rewarding, she said.

"There is nothing like living in recovery. People tend to respect me more and the hope that they give me by cheerleading me on is awesome," Clement said. "Knowing that people believe in me enough to ask me to be part of a team that pursues the bigger picture in the mental health world offers me hope and a bright future."

She has made it a point to advocate and be a voice for others who have not yet reached a point of recovery in their lives.

"If I can help one person not to have to go through what I've been through during my dark days and help them achieve recovery, then that's worth all the time I put into it. It gives so much hope," Clement said. ◆

NAMI Recognizes Sandra Caron with Ken Steele Award

The National Alliance on Mental Illness (NAMI) honored Certified Peer Support Specialist Sandra Caron this year with its Ken Steele Award. The award was presented at the NAMI 2015 San Francisco Conference on July 6.

The Ken Steele Award is a recognition of outstanding contributions by an individual living with mental illness to improve the quality of life, increase empowerment and promote integration and inclusion for other people living with mental illness.

The NAMI Consumer Council selected Sandra this year for her many achievements, including the work she does in Mississippi as a Certified Peer Support Specialist (CPSS) and a CPSS Ambassador promoting recovery, her participation in NAMI Signature programs – Connection, In Our Own Voices, and Peer-To-Peer – and her former role as the Chair of the NAMI Consumer Council.

Sandra continues to advocate for consumer rights, and encourages education for those with a lived

experience of mental illness, their family members and professionals. The NAMI Consumer Council applauds Sandra Caron for her passion and dedication. Her life is a testimony to living with the determination to overcome all obstacles to lead a reclaimed.

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Sandra first took a NAMI Connection course in 2007, but said the thought of being an advocate had never entered her mind.

"However, an amazing journey came from that experience, leading me into advocacy," she said. "The concept of recovery from serious mental illness is one that individuals living with mental illness rarely realize is a possibility. As a member, and now past Chair of the NAMI Consumer Council, being nominated, much less winning the Ken Steele Award, has been a humbling experience."

Sandra commended the Mississippi Department of Mental Health for their support of training and utilizing peer support. She said she is contacted by peers across the United States inquiring how Mississippi has had the success it is having with the CPSS program.

She thanked Dr. Debbie Ferguson, Dr. Steve Smith, and Jennifer Savell, along with the Program Staff at Central Mississippi Residential Center.

"With Peer Support being still relatively new in the state of Mississippi, the staff, and myself, began a new journey," she said. "I also want to thank NAMI members Ann Jensen, and Ricky Quinn, who both taught me that family members deserve a quality of life, and helped me to understand that family members as well need support." ◆

Legislature Passes 'Patricia's Law'

As the Mississippi Legislature met in the opening days of the 2015 session, some individuals who have lived with mental illness asked legislators to consider a law that could protect their privacy and ensure their self-worth stays intact during difficult times in their lives.

The request was prompted by an email North Mississippi State Hospital received in 2013 that profiled a difficult problem faced by someone who received services there – her name and mugshot were online despite the fact she had not been charged with a crime, but she had waited in a jail for a bed to come available at the hospital.

"I have only to Google my name, and there is my mugshot," said this email.

To avoid situations like this happening to others, the Mississippi Legislature this year passed a bill that exempts the publication of mugshots from the Public Records Act if the person being booked is held in custody solely on the basis of his or her mental health. Senator Nancy Collins introduced a similar bill in the 2014 session, but it did not make it through the committee process. This legislative language is being called "Patricia's Law" and is included in House Bill 545.

Patricia was once a patient at North Mississippi State Hospital. She was admitted through the court commitment process, but had to wait at a jail before her admission. While there, she had a mugshot taken that, under the state's public records laws, was a public document.

As a public document, that mugshot found its way online to the growing industry of businesses that publish mugshots and arrest information online.

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Many of these sites charge fees to remove the photos, and there is another industry of sites that don't host any pictures, but do charge fees to try to remove those mugshots from the Internet. While many mugshots are of individuals who are convicted of crimes, photos are published whether charges get dropped, a person is found innocent or, in this case, even if someone is held only to await a bed in a mental health treatment program.

There are ways to remove these photos, but the nature of the Internet often means that once something is publicly placed online, it is essentially online forever. Even if someone pays a site to remove a photo, that picture may have been duplicated by another site, and publicly-available backups and caches of sites can often keep data online indefinitely.

The email Patricia sent to North Mississippi State Hospital goes on to say that while the paperwork related to her is still confidential, her name and face were online in a mugshot, easily found by a simple Google search of her name. It was shocking, embarrassing, and, believing it made her look like a criminal, even made her regret receiving mental health services.

Dozens of these web sites have sprung up online in the past several years, along with those that charge for the removal of the photos – as much as $400 to take down one single picture. Patricia was struggling with depression, not committing any crimes, but she was still asked to pay to remove her mugshot from the Internet, and there's no guarantee it won't be placed online again at another web site. It creates a situation that many critics have compared to extortion.

"Including these mugshots along with those of accused and convicted criminals only furthers the fear and negative stereotypes many people have towards individuals who have a mental illness," said Debbie Hall, Public Relations Director at North Mississippi State Hospital. "Having a mental illness is not a crime."

A growing number of states have moved to regulate this industry, introducing bills that often require these site operators to remove without a fee photos and information about people who were not convicted of crimes. Georgia, New Jersey, Oregon, Texas and Utah have all passed bills in recent years to regulate these sites. Senator Collins and several other Mississippi legislators will be working to pass a similar bill in the 2015 legislative session.

"The best way we can address this situation is to pass a bill like the one Senator Collins presented last year," Hall said. "We need to be sure that a person who is in need of mental health services does not have his or her picture posted online for others to copy and post for profit.

"I promised Patricia I would do all I could to make sure this matter was addressed. We can't make this 'right' for her, but we can change things so something like this doesn't happen in the future."

Mental Health Association Of South Mississippi Offers WRAP Training

Mississippians living with a mental illness could soon have a new tool to help maintain their mental wellness thanks to training workshops hosted by the Mental Health Association of South Mississippi.

The association is available for workshops across the state in Wellness Recovery Action Planning, also known as WRAP. WRAP is an evidence-based practice developed by Dr. Mary Ellen Copeland, an internationally-known author and mental health advocate. Through a grant awarded by the Substance Abuse and Mental Health Services Administration (SAMHSA), the Mental Health Association of South Mississippi (MHASM) is able to facilitate WRAP training around the state.

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"WRAP is an evidence-based practice developed by a group of people who experience mental health challenges," said MHASM Executive Director Kay Daneault. "These folks learned that they can identify what makes them well, and then use their own wellness tools to relieve difficult feelings and maintain wellness. The result has been recovery and long-term stability."

WRAP IS AN EVIDENCE-BASED PRACTICE DEVELOPED BY A GROUP OF PEOPLE WHO EXPERIENCE MENTAL HEALTH CHALLENGES

In these workshops, facilitators will teach others how to apply those same ideals to their lives, identifying conditions and things that make them unwell or help them to remain healthy, and eliminating the negative while bolstering the positive. The sessions are presented in practical, day-to-day terms, and they can also complement other treatment options that may be used by an individual.

WRAP can be used by individuals with a variety of medical conditions, not just mental illness. It can be an effective tool for individuals with conditions such as diabetes, substances use issues, trauma-related issues and even the stress resulting from changes in someone's job.

It can be used as a framework to guide interpersonal relationships, peer support, groups, agencies and even organizations, Daneault said. The workshops offered by the Mental Health Association of South Mississippi are intended for self-care and can be used in businesses to help employees learn to handle stress better and increase productivity.

WRAP is something individuals develop for themselves with ideas explored in the group. During the training, participants will develop wellness tools, daily wellness maintenance plans, plan for crises and discuss factors that contribute to stress management. Wellness tools are activities that someone enjoys and help them feel better. They could be activities that have been used in the past, or something someone would like to try using in the future.

Discussions also focus on how to use these tools when needed. For instance, are these tools events or activities someone would want to be doing every day, or only when particular feelings or experiences arise? They could be as simple as making sure to eat healthy, get plenty of rest or make sure not to let any daily hygiene habits slip.

During the WRAP training, participants can take part in a voluntary roundtable in which they discuss "triggers," or those things that may negatively affect their mental health. Once again, these can sometimes be simple

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events, like receiving a bill or arguing with family members, but they may add to someone's stress level and affect their mental wellness.

They also discuss the early warning signs they may display when their mental wellness begins to decline. It may be more expressions of anxiety or grouchiness for some people, or it may be more reckless behavior or social isolation for others.

Participants in WRAP courses can take all of this information – this "Wellness Toolbox" – they have developed, and share it with others in their life. This way, their friends, family members, coworkers and others of their choosing have information to recognize the signs when someone needs more help and support, and the best ways to provide that support to that specific person.

"Facilitators were certified through a week long intense training by the Mary Ellen Copeland Center. Working in pairs, facilitators can tailor a session to a half, full or two day WRAP," Daneault said. "The sessions are open to the general public, and have been a great resource for psychosocial rehabilitation centers, businesses and other groups."

Sessions can also be tailored to focus specifically on addictions, trauma and abuse, WRAP for veterans, and even to discuss WRAP in the workplace.

The WRAP workshops also offer continuing education units for the following disciplines: Mental Health Therapist (DMH), IDD Therapist (DMH), DMH Administrator (DMH), Case Management (DMH), Addiction Counseling (DMH), Social Worker (NASW) and Counselor/ LPC (NBCC).

The Mental Health Association of South MS (MHASM) is a non-profit 501c3 organization that has been in existence since 1963. Other programs it offers include a drop-in center, homeless outreach and supportive housing, peer support and educational opportunities.

To schedule or participate in a WRAP, contact Kay Daneault, kay@msmentalhealth.org or Melody Worsham, melody@msmentalhealth.org or call 228-864-6274. For more information, please visit http://www.mentalhealthrecovery.com/wrap/.

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MISSISSIPPI DEPARTMENT OF MENTAL HEALTH COMMUNITY MENTAL HEALTH SERVICES FY 2016 – 2017 STATE PLAN

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SECTION I
STATE INFORMATION

FACE SHEET COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

I. State Agency to be the Grantee for the Block Grant

Agency Name: Mississippi Department of Mental Health

Organizational Unit: Bureau of Community Services

Mailing Address: 239 North Lamar Street, 1101 Robert E. Lee Building

City: Jackson

Zip Code: 39201

II. Contact Person for the Grantee of the Block Grant

First Name: Diana

Last Name: Mikula

Agency Name: Mississippi Department of Mental Health

Mailing Address: 239 North Lamar Street, 1101 Robert E. Lee Building

City: Jackson

Zip Code: 39201

Telephone: 601-359-1288

Fax: 601-359-6295

Email Address: diana.mikula@dmh.state.ms.us

III. State Expenditure Period (Most recent State expenditure period that is closed out)

From: 7/1/2013

To: 6/30/2014

IV. Date Submitted

Submission Date:

Revision Date:

V. Contact Person Responsible for Application Submission

First Name: Jake

Last Name: Hutchins

Telephone: 601-359-1288

Fax: 601-359-6295

Email Address: jake.hutchins@dmh.state.ms.us

Letter of Designation from Governor

Letter for Submission of State Plan

Certifications and Assurances

MISSISSIPPI DEPARTMENT OF MENTAL HEALTH MISSION STATEMENT

Supporting a better tomorrow by making a difference in the lives of Mississippians with mental illness, substance abuse problems and intellectual/developmental disabilities one person at a time.

MISSISSIPPI DEPARTMENT OF MENTAL HEALTH VISION STATEMENT

We envision a better tomorrow where the lives of Mississippians are enriched through a public mental health system that promotes excellence in the provision of services and supports.

A better tomorrow exists when…

- All Mississippians have equal access to quality mental health care, services, and supports in their communities.
- People actively participate in designing services.
- The stigma surrounding mental illness, intellectual/developmental disabilities, substance abuse, and dementia has disappeared.
- Research, outcome measures, and technology are routinely utilized to enhance prevention, care, services and supports.

Philosophy of the Department of Mental Health

The Department of Mental Health is committed to developing and maintaining a comprehensive, statewide system of prevention, service and support options for adults and children with mental illness or emotional disturbance, alcohol/drug problems, and/or intellectual or developmental disabilities, as well as adults with Alzheimer's disease and other dementia. The DMH supports the philosophy of making available a comprehensive system of services and supports so that individuals and their families have access to the least restrictive and appropriate level of services and supports that will meet their needs. Our system is person-centered and is built on the strengths of individuals and their families while meeting their needs for special services. The DMH strives to provide a network of services and supports for persons in need and the opportunity to access appropriate services according to their individual needs/strengths. The DMH is committed to preventing or reducing the unnecessary use of inpatient or institutional services when individuals' needs can be met with less intensive or least restrictive levels of care as close to their homes and communities as possible. Underlying these efforts is the belief that all components of the system should be person-centered, community-based, and outcomes and recovery-oriented.

Core Values and Guiding Principles of the Department of Mental Health

People: We believe people are the focus of the public mental health system. We respect the dignity of each person and value their participation in the design, choice, and provision of services to meet their unique needs.

Community: We believe the community-based service and support options should be available and easily accessible in the communities where people live. We believe that services and support options should be designed to meet the particular needs of the person.

Commitment: We believe in the people we serve, our vision and mission, our workforce, and the community-at-large. We are committed to assisting people in improving their mental health, quality of life, and their acceptance and participation in the community.

Excellence: We believe services and supports must be provided in an ethical manner, met established outcome measures, and be based on clinical research and best practices. We also emphasize the continued education and development of our workforce to provide the best care possible.

Accountability: We believe it is our responsibility to be good stewards in the efficient and effective use of all human, fiscal, and material resources. We are dedicated to the continuous evaluation and improvement of the public mental health system.

Collaboration: We believe that services and supports are the shared responsibility of state and local governments, communities, families, and service providers. Through open communication, we continuously build relationships.

Integrity: We believe the public mental health system should act in an ethical and trustworthy manner on a daily basis. We are responsible for providing services based on principles in legislation, safeguards, and professional codes of conduct.

Awareness: We believe awareness, education, prevention and early intervention strategies will minimize the behavioral health needs of Mississippians. We also encourage community education and awareness to promote an understanding and acceptance of people with behavioral health needs.

Innovation: We believe it is important to embrace new ideas and change in order to improve the public mental health system. We seek dynamic and innovative ways to provide evidence-based services/supports and strive to find creative solutions to inspire hope and help people obtain their goals.

Respect: We believe in respecting the culture and values of the people and families we serve. We emphasize and promote diversity in our ideas, our workforce, and the services/supports provided through the mental health system.

SECTION II
PLANNING STEPS

Step 1: Assessment of the Strengths and Needs of the Service System

Overview of the State Mental Health System

The State Public Mental Health Service System is administered by the Mississippi Department of Mental Health (DMH), which was created in 1974 by an act of the Mississippi Legislature, Regular Session. The creation, organization, and duties of the DMH are defined in the annotated Mississippi Code of 1972 under Sections 41-4-1 through 41-4-23.

The Service Delivery System is comprised of 3 major components: 1) state-operated programs and community services programs, 2) regional community mental health centers, and 3) other nonprofit/profit service agencies/organizations.

The Board of Mental Health governs the DMH. The Board's nine members are appointed by the Governor of Mississippi and confirmed by the State Senate. By statute, the Board is composed of a physician, a psychiatrist, a clinical psychologist, a social worker with experience in the field of mental health, and one citizen representative from each of Mississippi's five congressional districts (as existed in 1974). Members' 7-year terms are staggered to ensure continuity of quality care and professional oversight of services.

The Department of Mental Health Central Office is responsible for the overall statewide administrative functions and is located in Jackson, Mississippi. The Central Office is headed by an Executive Director and consists of bureaus.

The Bureau of Administration works in concert with all bureaus to administer and support development and administration of mental health services in the state.

The Bureau of Community Mental Health Services has the primary responsibility for the development and implementation of community-based services to meet the needs of adults with serious mental illness and children with serious emotional disturbance, as well as to assist with the care and treatment of persons with Alzheimer's disease/other dementia. The Bureau of Community Services provides a variety of services through the following divisions: Division of Children and Youth Services, Division of Adult Grants Management, Division of Alzheimer's Disease and Other Dementia, Division of State Planning and the Division of Adult Crisis Response.

The Bureau of Alcohol and Drug Services is responsible for the administration of state and federal funds utilized in the prevention, treatment and rehabilitation of persons with substance abuse problems. The overall goal of the state's substance abuse service system is to provide a continuum of community-based, accessible services, including prevention, outpatient, detoxification, community-based primary and transitional residential treatment, inpatient and recovery support.

The Bureau of Mental Health is responsible for the planning, development, and supervision of an array of services for individuals served at the state's six state behavioral health programs, which include services for individuals with mental illness, alcohol/drug services and nursing homes. This public service delivery system is comprised of four psychiatric hospitals; Central Mississippi Residential Center, a mental health community living program; and the Specialized Treatment Facility, a psychiatric residential treatment facility for adolescents with mental illness and a secondary need of substance use prevention/treatment.

The Bureau of Intellectual and Developmental Disabilities is responsible for planning, development, and supervision of an array of services for individuals in the state with intellectual and developmental disabilities. This public service delivery system is comprised of five state-operated comprehensive IDD programs for individuals with intellectual and developmental disabilities, the Mississippi Adolescent Center, an adolescent rehabilitation center for youth with intellectual and developmental disabilities whose behavior requires specialized treatment, regional community mental health centers, and other nonprofit community agencies/organizations that provide community services.

The Bureau of Quality Management, Operations and Standards is responsible for the development of DMH standards of care for providers, provider certification and compliance with DMH standards, oversight of agency and provider emergency management/disaster response systems, management of the serious incident reporting system for DMH certified providers, operation of DMH's information and referral services, and oversight of constituency services.

The Bureau of Outreach, Planning and Development is responsible for the agency's strategic planning process, internal and external communications, public awareness campaigns, transformation to a Person-Centered and Recovery Oriented System of Care, special projects, workforce development, and professional licensure and certification

Functions of the Mississippi Department of Mental Health

State Level Administration of Community-Based Mental Health Services: The major responsibilities of the state are to plan and develop community mental health services, to set Operational Standards for the services it funds, and to monitor compliance with those Operational Standards. Provision of community mental health services is accomplished by contracting to support community services provided by regional commissions and/or by other community public or private nonprofit agencies.

State Certification and Program Monitoring: Through an ongoing certification and review process, the DMH ensures implementation of services which meet the established Operational Standards.

State Role in Funding Community-Based Services: The DMH's funding authority was established by the Mississippi Legislature in the Mississippi Code, 1972, Annotated, Section 41-45. Except for a 3% state tax set-aside for alcohol services, the DMH is a general state tax fund agency. Agencies or organizations submit to DMH for review proposals to address needs in their local communities. The decision-making process for selection of proposals to be funded are based on the applicant's fulfillment of the requirements set forth in the RFP, funds available for existing programs, funds available for new programs, funding priorities set by state and/or federal funding sources or regulations, and the State Board of Mental Health.

Services/Supports Overview: The DMH provides and/or financially supports a network of services for people with mental illness, intellectual/developmental disabilities, substance abuse problems, and Alzheimer's disease and/or other dementia. It is our goal to improve the lives of Mississippians by supporting a better tomorrow…today. The success of the current service delivery system is due to the strong, sustained advocacy of the Governor, the State Legislature, the Board of Mental Health, the Department's employees, consumers and their family members, and other supportive individuals. Their collective concerns have been invaluable in promoting appropriate residential and community service options.

Service Delivery System: The mental health service delivery system is comprised of three major components: 1) state-operated programs and community services programs, 2) regional community mental health centers, and 3) other nonprofit/profit service agencies/organizations.

State-Operated Programs: DMH administers and operates four state behavioral health programs, one mental health community living program, a specialized behavioral health program for youth, five regional programs for persons with intellectual and developmental disabilities, and a specialized program for adolescents with intellectual and developmental disabilities. These programs serve designated counties or service areas and offer community living and/or community services. The behavioral health programs provide inpatient services for people (adults and children) with serious mental illness (SMI) and substance abuse. These programs include: Mississippi State Hospital, North Mississippi State Hospital, South Mississippi State Hospital, East Mississippi State Hospital, and Specialized Treatment Facility. Nursing home services are also located on the grounds of Mississippi State Hospital and East Mississippi State Hospital. In addition to the inpatient services mentioned, the behavioral health programs also provide transitional, community-based care. The Specialized Treatment Facility is a specialized behavioral health program for adolescents with mental illness and a secondary need of substance abuse prevention/treatment. Central Mississippi Residential Center is a community living program for persons with mental illness. The programs for persons with intellectual and developmental disabilities provide residential services. These programs include Boswell Regional Center, Ellisville State School, Hudspeth Regional Center, North Mississippi Regional Center, and South Mississippi Regional Center. The programs are also a primary vehicle for delivering community services throughout Mississippi. Mississippi Adolescent Center is a specialized program for adolescents with intellectual and developmental disabilities.

Regional Community Mental Health Centers (CMHCs): The CMHCs operate under the supervision of regional commissions appointed by county boards of supervisors comprising their respective service areas. The 14 CMHCs make available a range of community-based mental health, substance abuse, and in some regions, intellectual/developmental disabilities services. CMHC governing authorities are considered regional and not state-level entities. The DMH is responsible for certifying, monitoring, and assisting CMHCs. CMHCs are the primary service providers with whom the DMH contracts to provide community-based mental health and substance abuse services.

Other Nonprofit/Profit Service Agencies/Organizations: These agencies and organizations make up a smaller part of the service system. They are certified by the DMH and may also receive funding to provide community-based services. Many of these nonprofit agencies may also receive additional funding from other sources. Services currently provided through these nonprofit agencies include community-based alcohol and drug services, community services for persons with intellectual/developmental disabilities, and community services for children with mental illness or emotional problems.

Administration of Community-Based Mental Health Services

State Level Administration of Community-Based Mental Health Services: The major responsibilities of the state are to plan and develop community mental health services, to set Operational Standards for the services it funds, and to monitor compliance with those Operational Standards. Provision of community mental health services is accomplished by contracting to support community services provided by regional commissions and/or by other community public or private nonprofit agencies. The DMH is an active participant in various interagency efforts and

initiatives at the state level to improve and expand mental health services. The DMH also supports, participates in, and/or facilitates numerous avenues for ongoing communication with consumers, family members, and services providers.

State Mental Health Agency's Authority in Relation to Other State Agencies: The DMH is under separate governance by the State Board of Mental Health but oversees mental health, intellectual/developmental disabilities, and substance abuse services, as well as limited services for persons with Alzheimer's disease/other dementia. The DMH has no direct authority over other state agencies, except as provided for in its state certification and monitoring role; however, it has maintained a long-term philosophy of interagency collaboration with the Office of the Governor and other state and local entities that provide services to individuals with disabilities, as reflected in the State Plan. The role of State agencies in the delivery of behavioral health services is addressed in: Support of State Partners.

MISSISSIPPI DEPARTMENT OF MENTAL HEALTH COMPREHENSIVE COMMUNITY MENTAL HEALTH CENTERS	
Region 1: Coahoma, Quitman, Tallahatchie, Tunica	Region One Mental Health Center Karen Corley, Interim Executive Director 1742 Cheryl Street P. O. Box 1046 Clarksdale, MS 38614 (662) 627-7267
Region 2: Calhoun, Lafayette, Marshall, Panola, Tate, Yalobusha	Communicare Sandy Rogers, Ph.D., Executive Director 152 Highway 7 South Oxford, MS 38655 (662) 234-7521
Region 3: Benton, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Union	LIFECORE Health Group Robert Smith, Executive Director 2434 South Eason Boulevard Tupelo, MS 38801 (662)640-4595
Region 4: Alcorn, Prentiss, Tippah, Tishomingo, DeSoto	Timber Hills Mental Health Services Charlie D. Spearman, Sr., Executive Director 303 N. Madison P. O. Box 839 Corinth, MS 38835-0839 (662) 286-9883
Region 6: Attala, Carroll, Grenada, Holmes, Humphreys, Leflore, Montgomery, Sunflower	Life Help Phaedre Cole, Executive Director 2504 Browning Road P. O. Box 1505 Greenwood, MS 38935-1505 (662) 453-6211
Region 7: Choctaw, Clay, Lowndes, Noxubee, Oktibbeha, Webster, Winston	Community Counseling Services Jackie Edwards, Executive Director 1032 Highway 50 P.O. Box 1336 West Point, MS 39773 (662) 524-4347
Region 8: Copiah, Madison, Rankin, Simpson, Lincoln	Region 8 Mental Health Services Dave Van, Executive Director 613 Marquette Road P. O. Box 88 Brandon, MS 39043 (601) 825-8800 (Service); (601) 824-0342 (Admin.)
Region 9: Hinds	Hinds Behavioral Health Kathy Crockett, Ph.D., Executive Director 3450 Highway 80 West P.O. Box 777 Jackson, MS 39284 (601) 321-2400

Region 10: Clarke, Jasper, Kemper, Lauderdale, Leake, Neshoba, Newton, Scott, Smith	Weems Community Mental Health Center Maurice Kahlmus, Executive Director 1415 College Road P. O. Box 2868 Meridian, MS 39302 (601) 483-4821
Region 11: Adams, Amite, Claiborne, Franklin, Jefferson, Lawrence, Pike, Walthall, Wilkinson	Southwest MS Mental Health Complex Steve Ellis, Ph.D., Director 1701 White Street P. O. Box 768 McComb, MS 39649-0768 (601) 684-2173
Region 12: Covington, Forrest, Greene, Jefferson Davis, Jones, Lamar, Marion, Perry, Wayne	Pine Belt Mental Healthcare Resources Jerry Mayo, Executive Director 103 South 19th Avenue P. O. Box 18679 Hattiesburg, MS 39404-86879 (601) 544-4641
Region 13: Hancock, Harrison, Pearl River, Stone	Gulf Coast Mental Health Center Jeffrey L. Bennett, Executive Director 1600 Broad Avenue Gulfport, MS 39501-3603 (228) 863-1132
Region 14: George, Jackson	Singing River Services Sherman Blackwell, II, Executive Director 3407 Shamrock Court Gautier, MS 39553 (228) 497-0690
Region 15: Warren, Yazoo	Warren-Yazoo Mental Health Services Bobby Barton, Executive Director 3444 Wisconsin Avenue P. O. Box 820691 Vicksburg, MS 39182 (601) 638-0031

Strengths and Needs of the Service System

Strengths: Children with Serious Emotional Disturbance (SED) and Their Families

- The Mississippi Transitional Outreach Program (MTOP), a Children's Mental Health Initiative targeting transitional youth age, 14–21 years, entered into the sixth and final year of implementation on October 1, 2014. Three local community mental health center regions are implementing the program which provides evidence-based practices, wraparound facilitation, and training for professionals and youth, and education and resources on independent living skills for youth enrolled. On July 1, 2013, the DMH received a four year grant to expand this program to two additional counties.

- The DMH established and continues to support an Interagency State-Level Case Review Team for children with serious emotional disturbances with complex needs that usually require the intervention of multiple state agencies. The DMH provides flexible funding to this state-level team and to local interagency Making A Plan (MAP) Teams that are designed to implement cross-agency planning to meet the needs of youth most at risk of inappropriate out-of-home placement. Another example is the long-term collaboration of the DMH and the Department of Human Services (DHS) in the provision and monitoring of therapeutic foster care services and therapeutic group home services, as well as adolescent offender programs across the state.

- The DMH and the Division of Children's Services have demonstrated a long-term commitment to training of providers of mental health services, as well as cross-training staff from other child and family support service agencies. Collaborative training initiatives include Wraparound Facilitation and System of Care by staff at the Innovations Institute at the University of Maryland; MAP team development and expansion; Youth Suicide Prevention; Cultural Diversity; Trauma-Informed Care; juvenile mental health issues; and cross-system improvement trends and best practices.

- Efforts have been initiated to provide training in evidence-based practices to clinicians in the CMHCs and other nonprofit programs to improve responses to youth and families in crisis, including those with a history of trauma. Through contractual services with nationally certified trainers, the DMH provides collaborative learning for Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS).

- Efforts have been focused on the mental health needs of youth in the juvenile justice system, specifically the youth detention centers. The DMH continues to fund ten CMHCs for the provision of mental health services in the local detention centers. Services include assessments, Community Support Services, SPARCS (group therapy), Cognitive Behavioral Therapy (CBT), Wraparound Facilitation, and medication monitoring.

- The DMH has continued its efforts to provide community mental health services to schools, which is an important strategy in increasing the accessibility of services in rural areas and for families with working parent(s)/caregiver(s). Working with schools to identify and meet the mental health needs of children is also key to improving school attendance and performance of youth with serious emotional or behavioral challenges.

- The DMH, in collaboration with the Division of Medicaid and the University of Southern

Mississippi's School of Social Work, developed the Mississippi Wraparound Initiative.

Needs: Children with Serious Emotional Disturbance (SED) and Their Families

- Decrease turnover and increase the skill-level of children's community mental health and other providers of services for children/youth at the local level is ongoing, to better ensure continuity, equity and quality of services across all communities in the state, e.g., county health offices, teachers, foster care workers, and juvenile justice workers. Availability of additional workforce, particularly psychiatric/medical staff at the local community level, specializing in children's services, is an ongoing challenge in providing and improving services.

- Address children with co-occurring disorders of serious emotional disturbance (SED) and intellectual and developmental disabilities (IDD) in a more comprehensive way by expanding existing effective services and creating new approaches that facilitate cross-system collaboration and education.

- Continue to work to improve the information management system is needed to increase the quality of existing data, to expand capability to retrieve data on a timely basis, and to expand the types of data collected to increase information on outcomes is needed. This work should proceed with the overall goal of integrating existing and new data within a comprehensive quality improvement system.

- Continue to collaborate with the Division of Medicaid to further define and develop Intensive Outpatient Psychiatric Services and expand children's mental health provider's capacity to provide this intensive service.

- Continue the development of specialized curriculums for Certified Parent/Caregiver Support Specialists and Certified Youth/Young Adult Support Specialists.

Strengths: Services for Adults with Serious Mental Illness (SMI)

- Implementation of the comprehensive service system for adults with serious mental illness reflects the DMH's long-term commitment to providing services, as well as supports, that are accessible on a statewide basis.

- The DMH has created the Division of Crisis Response to address the development of crisis response capabilities in the state. The Division of Crisis Response consists of the Mobile Crisis Response Teams (MCeRTs), Crisis Intervention Teams (CIT), and Crisis Stabilization Units (CSU). MCeRTs are required to provide 24–hour a day face-to-face or telephone crisis response depending on the nature of the crisis. CITs are partnerships developed between local law enforcement, local mental health centers, and other social services agencies. CIT officers are trained to recognize mental health symptoms and de-escalation techniques.

- The DMH funds seven 16–bed CSUs and partially funds one 24–bed CSU throughout the state. The DMH also partially funds one 8–bed CSU for adolescents. All CSU takes voluntary as well as involuntary admissions. The DMH Help Line works in conjunction with the CMHC crisis response if face-to-face intervention is necessary for Help Line callers.

- The DMH also operates two 50–bed acute psychiatric hospitals for adults. The acute care/crisis services are located in the north and in the south part of the state.

- The DMH has developed a more specific strategic plan to address statewide implementation of an integrated service. MCeRTs assess adults and children with mental illness, substance abuse, and intellectual and developmental disabilities. MCeRTs are partnering with behavioral health centers to improve transitioning individuals from behavioral health centers back to home and community.

- The perspectives of families and individuals receiving services are important in planning, implementing, and evaluating the adult service system through involvement in numerous task forces, peer review process, provider education, and the person-directed planning process. The Bureau of Outreach, Planning and Development has implemented initiatives to provide more specific guidance regarding the purpose and structure of local advisory councils, has developed a draft of a manual to provide technical assistance to the local advisory councils, and plans to develop a strategy for dissemination of educational information to the local councils.

- The Bureau of Outreach, Planning and Development coordinates the Peer Support Specialist Program. This program is designed to promote the provision of quality Peer Support Services and to enhance employment opportunities for individuals with serious mental illness, substance abuse, and intellectual/developmental disabilities. Certified Peer Support Specialists are required by the DMH to be an integral component of PACT and MCeRT.

- The Bureau of Outreach, Planning and Development oversees the Peer Review Process for the DMH using The Council on Quality Leadership's Personal Outcome Measures © to assess the impact of services on the quality of life for the people receiving services. Individuals and family members are trained to conduct interviews to determine if outcomes are present for the individual and if the supports needed are present in order to achieve those outcomes. The Division of Recovery and Resiliency maintains the commitment to ensure individuals and family members have the skills and competencies needed for meaningful participation in designing and planning the services they receive as well as evaluating how well the system meets and addresses their expressed needs.

- The Office of Consumer Support is responsible for maintaining a 24–hour, 7–days a week service for responding to needs for information, referral, and crisis intervention by a National Suicide Prevention Lifeline. The Office of Consumer Support responds and attempts to resolve consumer grievances about services operated and/or certified by the DMH.

- The DMH has contracted with the Technical Assistance Collaborative (TAC) to develop a statewide housing plan. The State will request funding for this project through Mississippi Home Corporation. The goal is to increase the number of safe, decent affordable housing options that include a range of choices for Mississippians.

- The DMH will address housing and support service needs of persons who are experiencing chronic homelessness who have a substance use or co-occurring use and mental health disorder through the Cooperative Agreement to Benefit Homeless Individuals (CABHI).

- The DMH provided funding to develop four pilot sites to offer Supported Employment to 75 individuals with mental illness. The sites are in Regions 2, 7, 10, and 12.

- Navigate is an evidence-based program designed to assist individuals who have experienced their first psychiatric episode. Navigate will be used in conjunction with PACT services to identify and alleviate future episodes.

- Trainers in both the adult and youth versions of Mental Health First Aid have been certified by the DMH. Mental Health First Aid is public education program that helps the public identify, understand, and respond to signs of mental illness, substance use disorders and behavioral disorders. These trainers provide education to community leaders including: pastors, teachers, and civic groups, and families and friends who are interested in learning more about mental health issues.

- All DMH Behavioral Health Programs have implemented person-centered discharge practices which are in-line with the agency's transformation to a person-centered and recovery oriented system of care.

- The DMH and the Think Again Network launched the Think Again Mental Health Awareness Campaign. This campaign addresses stigma that is often associated with seeking care. The campaign was designed to decrease the negative attitudes that surround mental illness, encourage young adults to support their friends who are living with mental health problems, and to increase public awareness about the availability and effectiveness of mental health services. The Think Again campaign has also partnered with the youth suicide prevention campaign, Shatter the Silence. These campaigns teach young adults about mental health and suicide prevention. The campaign engaged consumers in the planning, development, and implementation of the campaign.

- The Division of Alzheimer's Disease and Other Dementia provides awareness activities and educational training programs for family caregivers, direct care workers and other professional service providers, information and referral, adult day service programs, and annual education conferences. In addition, the Division works in collaboration with other state and nonprofit agencies on a variety of programs and projects such as development and implementation of the State Strategic Plan for Alzheimer's Disease, law enforcement training, adult day programs, in-home respite, education and training programs, development of outreach materials, and community caregiver support services.

- The Mississippi Department of Public Safety Board on Law Enforcement Officer Standards and Training accepted a proposal to include a course entitled, "Older Adults, Dementia, Elder Abuse and Silver Alert" into the Mandatory Basic Training Curriculum for all Law Enforcement Cadets.

- The DMH has provided more than 25 Applied Suicide Intervention Skills Trainings (ASIST) to professionals and community members. ASIST is a 2–day interactive session that teaches effective intervention skills while helping to build suicide prevention networks in the community.

- Mississippi has eight Programs of Assertive Community Treatment Teams (PACT). The teams serve: Region 3 (serves Lee County), Region 4 (serves DeSoto County), Region 6 (serves Leflore County), Region 9 (serves Hinds), Region 10 (serves Lauderdale County), Region 12 (serves Forrest and Lamar Counties), Region 12 (serves Harrison, Hancock, and Jackson Counties), and Region 15 (serves Warren and Yazoo Counties). PACT is a mental health service delivery model for facilitating community living, psychological rehabilitation

and recovery for persons who have the most severe and persistent mental illnesses and have not benefited from traditional outpatient/community services.

- The Specialized Planning Options to Transition (SPOT) Team is a collaborative effort between the DMH and the ARC of MS to assist individuals in need of support and services that exceeds their natural supports. With this coordination of systems and supports, it is the expectation that people with complex diagnoses and circumstances may be appropriately served and supported in community settings.

Needs: Services for Adults with Serious Mental Illness (SMI)

- For most people with a mental illness, employment is viewed as an essential part of their recovery. Most people with severe mental illness want to work as it is a typical role for adults in our society and employment is a cost-effective alternative to day treatment. Approximately 2 of every 3 people with mental illness are interested in competitive employment but less than 15% are employed due to lack of opportunities and supports.

- The DMH has chosen to develop and make available supported employment services based on the Dartmouth & Individual Placement and Supports Model (IPS). IPS supported employment helps people with severe mental illness work at regular competitive jobs of their choosing. Although variations of supported employment exist, IPS (Individual Placement and Support) refers to the evidence-based practice of supported employment.

- People who obtain competitive employment through IPS have increased income, improved self-esteem, improved quality of life, and reduced symptoms. Approximately 40% of clients who obtain a job with help from IPS become steady workers and remain competitively employed a decade later.

- Continued work to increase access to and to expand safe and affordable community-based housing options and housing related supports statewide for persons with serious mental illness is needed to support recovery. Accomplishing this goal will involve focusing the system response on supporting individuals to choose among community-based options for a stable home, based on their individual needs and preferences, which is consistent with the best practice of Permanent Supportive Housing (PSH).

- The Division of Crisis Response is planning to refocus efforts to reach more law enforcement entities as well as increase networking through the Department of Public Safety, and to explore avenues to reach additional crisis personnel such as ambulance drivers, volunteer fire departments and first responders. The DMH makes grants available to a CMHC region to provide training to law enforcement to facilitate the establishment of two Crisis Intervention Teams (CIT) in the state.

- Continued focus on improving transition of individuals from behavioral health centers back to their home communities is needed. The development of strategies to better target and expand intensive supports through a team approach is being addressed. The DMH will continue to enhance existing intensive supports and develop new protocols for follow-up services and aftercare.

- Work to improve the quality of data contained in the information management system, as well as to expand data analysis, continues. The goal is to integrate new and existing data into a comprehensive quality improvement system.

Step 2: Identification of the Unmet Service Needs and Critical Gaps

Children and Youth

Mississippi utilized final methodology for estimating prevalence of serious emotional disturbance among children and adolescents, as published by the National Center for Mental Health Services (CMHS) in the July 17, 1998, issue of the *Federal Register*. The estimated number of children, ages 9–17 years in Mississippi in 2013 is 369,698. Mississippi remains in the group of states with the highest poverty rate (29.1% age 5–17 in poverty, based on 2013 Federal poverty rates), therefore, estimated prevalence rates for the state (with updated estimated adjustments for poverty) would remain on the higher end of the ranges. The most current estimated prevalence ranges of serious emotional disturbances among children and adolescents for 2013 are as follows:

- Within the broad group (9–11%), Mississippi's estimated prevalence range for children and adolescents, ages 9–17 years, is 11–13% or from 40,667 – 48,061.
- Within the more severe group (5–7%), Mississippi's estimated prevalence range for children and adolescents, ages 9–17 years, is 7–9% or from 25,879 – 33,273.

For transitional age youth, the average of the prevalence rate of 5.4% (for adults) and the highest prevalence rate of 13% (for children) was calculated as 9.2% and applied to an estimate on the number of youth in the population, ages 18 up to 21 years of age (139,463), yielding an estimated prevalence of 12,831 in this transition age group.

In FY 2014, 34,194 children with serious emotional disturbance were served through the public community mental health centers and other nonprofit providers of community services (*Mississippi State Plan for Community Mental Health Services Implementation Report*, FY 2014).

Adults

Mississippi utilized the final federal methodology for estimating prevalence of serious mental illness among adults, as published by the National Center for Mental Health Services in the June 24, 1999, issue of the *Federal Register*. The estimated number of adults in Mississippi, ages 18 years and above is 2,228,376 based on *U.S. Census 2013* population estimates. According to the "final federal methodology," published by the National Center for Mental Health Services for estimating prevalence of serious mental illness among adults (in *Federal Register*, June 24, 1999), the estimated prevalence of serious mental illness among adults in Mississippi, ages 18 years and above is 5.4 % or 120,332 in 2013.

In FY 2014, 59,300 adults with serious mental illness were served through the public community mental health system in Mississippi. Services were provided in all 14 mental health regions and by the community services division of one psychiatric hospital to 11,034 individuals with co-occurring disorders (*Mississippi State Plan for Community Mental Health Services*, FY 2014.)

The Mississippi Board of Mental Health and the DMH developed a Strategic Plan five years ago. The Strategic Plan was developed with the help of partners across the state to guide the future of the agency. The main goal of the Plan was to create a living, breathing document. The Plan was developed with input from consumers, family members, advocates, community mental health centers, service providers, professional associations, individual communities, DMH staff, and other agencies. The DMH wanted to make strides toward developing a community-based service system

which focuses on evidence-based practices and improves access to care.

The Bureau of Community Services used the report published by *Mental Health America Parity or Disparity: The State of Mental Health in America 2015*, to assist us in identifying gaps in our services for adults and children. The report identifies indicators available across all fifty states and the District of Columbia. The report is organized in general categories relating to mental health status and access to mental health services. The data allows the DMH to see how our state is ranked among the other states.

The DMH receives feedback through the review of the State Plan by the Mississippi State Mental Health Planning and Advisory Council and the Mississippi Board of Mental Health. The DMH has also benefited greatly from the continuity of its relationship with the Mississippi State Mental Health Planning and Advisory Council, which includes representation from major family and consumer advocacy groups. The DMH sends out a statewide satisfaction survey for adults and children as another means of collecting feedback from individuals served by the system. Family members, consumers, local service providers, and representatives from other agencies participate on numerous task forces and coalitions.

In addition to considering estimates of prevalence for targeted groups, results of a statewide consumer survey, public forums, and focus group meetings were used to identify and categorize major areas of need across disability groups, including individuals with mental illness. Major needs for transportation and housing were identified. As part of the housing planning component of the TTI project, the Technical Assistance Collaborative, Inc. (TAC) provided the DMH with state level population data and various indicators of poverty and disability. While there continues to be a need for transportation and housing for targeted groups, the information and data provided by TAC has been used on occasions to educate public officials, stakeholders, and funding sources regarding the need for expanding and increasing transportation and housing. The TAC data has also been used to develop applications for funding to increase these services.

The DMH Division of Children and Youth Services gains additional information from both the individual service level and from a broader system policy level through regular interaction with representatives in other child service agencies on local Making A Plan (MAP) Teams, and through the work of the State-Level Interagency Case Review Team, two SAMHSA funded initiatives, and the Mississippi Transitional Outreach Program described in more detail in the State Plan.

The DMH management staff receives regular reports from the Division of Office of Consumer Support (OCS), which tracks requests for services by major category, as well as receives and attempts to resolve complaints and grievances regarding programs operated and/or certified by the agency. This avenue allows for additional information that may be provided by individuals who are not currently being served through the public system.

Step 3: Prioritization of State Planning Activities

Table 2 Plan Year FY 2016-2017:

	Priority Areas
1	Comprehensive Community-Based Mental Health Systems for Children and Youth with SED
2	Interagency Collaboration for Children and Youth with SED
3	Expansion of System of Care for Children and Youth with SED
4	Integrated Services for Children and Youth with SED
5	Recovery Supports
6	Prevention of Substance Abuse and Mental Illness
7	Health Care and Health Systems Integration
8	Trauma and Justice
9	Comprehensive Community-Based Mental Health Systems for Adults with SMI
10	Targeted Services to Rural and Homeless Adults with SMI
11	Health Information Technology
12	Workforce Development

Step 4: Objectives, Strategies and Performance Indicators

The primary target populations addressed in the FY 2016-2017 State Plan are children with serious emotional disturbances (SED) and adults with serious mental illness (SMI).

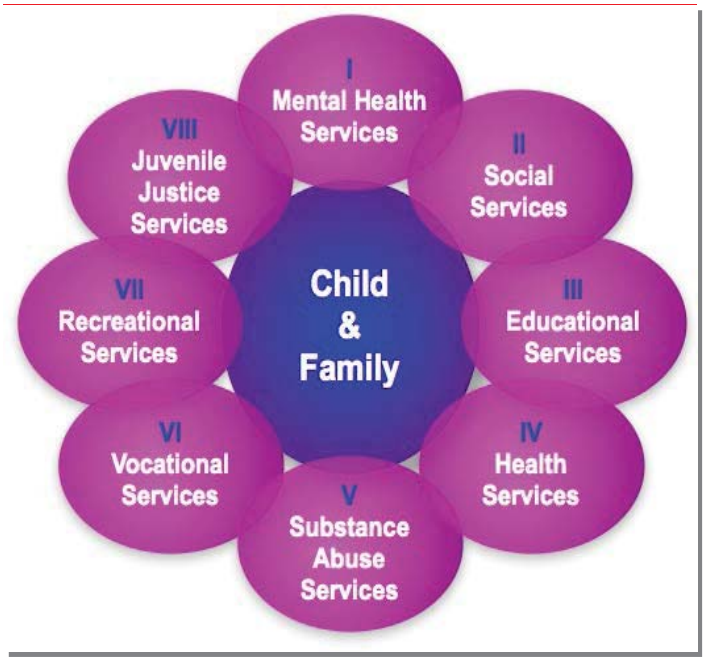
State Priority 1: Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

Children and adolescents with a serious emotional disturbance are defined as any individual, from birth up to age 21, who meets one of the eligible diagnostic categories as determined by the current DSM and the identified disorder has resulted in functional impairment in basic living skills, instrumental living skills, or social skills. The need for mental health as well as other special needs services and support services is required by these children/youth and families at a more intense rate and for a longer period than children/youth with less severe emotional disorders/disturbance in order for them to meet the definition's criteria.

The majority of public community mental health services for children with serious emotional disturbance in Mississippi are provided through the 14 regional mental health/mental retardation commissions. Other nonprofit community providers also make available community services to children with serious emotional disturbances and their families - primarily community-based residential services, specialized crisis management services, intensive home/community-based services, family education and prevention/early intervention services. Public inpatient services are provided directly by the DMH (described further later under this criterion). The DMH remains committed to preventing and reducing hospitalization of individuals by increasing the availability of and access to appropriate community mental health services. Activities that may reduce hospitalization include the State-Level Review/MAP Teams, Pre-evaluation Screening and Civil Commitment Services, Acute Inpatient Services, Mobile Crisis/Emergency Response Teams, Medication Maintenance, Intensive Home/Community Based Services, Wraparound Facilitation, Day Treatment, Therapeutic Foster Care, Therapeutic Group Homes, and Community-Based Chemical Dependency Treatment Services. Medically necessary mental health services that are included on an approved plan of care are also available from approved providers through the Early Periodic Screening, Diagnosis and Treatment Program, funded by the Division of Medicaid. Those services are provided by psychologists and clinical social workers and include individual, family and group, and psychological and developmental evaluations.

Mississippi's System of Care for Children and Youth

Mississippi recognizes that a System of Care (SOC) is a coordinated network of community-based services and supports based on the values of cultural/linguistic competency, family-driven and youth-guided care. A System of Care is not a program, but a philosophy of how care should be delivered. A System of Care considers all life domains rather than addressing just the mental health treatment needs in isolation. There are eight overlapping dimensions:



Mississippi was one of the first states to create a foundation for systems of care. Beginning with state legislation in 1993, Mississippi developed local multidisciplinary assessment and planning teams for youth with multiple agencies and established a Children's Advisory Council that focused on using pooled funding to better serve youth. Subsequent legislation established and strengthened a statewide system of care structure, with local Multidisciplinary Assessment and Planning (MAP) Teams around the state and the creation of the Interagency Coordinating Council for Children and Youth (ICCCY) and a mid-level management team, the Interagency System of Care Council (ISCC). Membership on the ICCCY includes Executive Directors of the following state of Mississippi child-serving agencies: Department of Education, Department of Mental Health, Department of Health, Department of Human Services, Division of Medicaid (Office of the Governor), Department of Rehabilitation Services, a representative from the Attorney General's Office, Families As Allies for Children's Mental Health, Inc., MAP Teams, The ARC of Mississippi, a local university, Early Childhood, a Child and Adolescent Psychiatrist, a youth/young adult, and a parent/caregiver. The ICCCY is charged with leading the development of the statewide system of care through the established Interagency System of Care Council (ISCC), consisting of a member of each state agency, a family member representing a family education and support organization, two special organization representatives, and a family member appointed by MS Families As Allies. The ISCC serves as the mid-level management teams with the responsibility of collecting and analyzing data and funding strategies, coordinating local MAP Teams, and applying for grants from public and private sources.

Priority Area 1	Comprehensive Community-Based Mental Health Systems for Children and Youth with SED
Goal: 1	To continue availability of funding for 3 prevention/specialized early intervention programs
Strategies	The DMH will continue to provide funding for 3 prevention/specialized early intervention programs for children/youth with SED identified by this program. These children/youth receive prompt evaluation and referrals, and appropriate therapeutic intervention to address the abuse; parents receive effective parenting skills training and family interventions, as well as other interventions designed to reunify and/or improve family relationships where possible.
Indicator	The number of programs to which the DMH makes available funding to help support prevention/early intervention – 3
Baseline Measurement	In FY 2014, the DMH provided funding for 3 prevention/specialized early intervention programs: Vicksburg Child Abuse Prevention Center, Vicksburg Family Development Center, and Operation Safe Kids operated by Region 7 CMHC/Community Counseling Services. These programs served 751 children and youth and 190 families in FY 2014. There were 3,467 referrals made to Operation Safe Kids.
First Year Target/Outcome Measurement	In FY 2016, the DMH will provide funding for 3 prevention/specialized early intervention programs.
Second Year Target/Outcome Measurement	In FY 2017, the DMH will provide funding for 3 prevention/specialized early intervention programs.
Description of Data	DMH RFPs/grant applications/grants
Criteria	Management Systems

***Footnote:** Prevention services supported through state funds from the DMH and provided to these families include: home visits, prenatal education, parenting education classes, preschool classes, sibling intervention groups, and specialized multidisciplinary sexual abuse prevention programs. The DMH also has a representative on the State Board for the Children's Trust Fund, which support projects across the state and provides financial assistance for direct services to prevent child abuse and neglect and to promote a system of services, laws, practices, and attitudes that enable families to provide a safe and healthy environment for their children.

Priority Area 1	Comprehensive Community-Based Mental Health Systems for Children and Youth with SED
Goal: 2	To continue to promote the development of children's mental health services available to infants and young children, birth to 5 years of age
Strategies	Technical assistance activities and training opportunities will be facilitated by the Division of Children and Youth Services staff and other experts in the field upon request, including on-site visits, to providers interested in developing children's mental health services to serve children, birth to 5 years of age, with mental health issues and their families.
Indicator	The DMH Division of Children and Youth Services staff will assist in coordinating technical assistance and training activities to service

	providers on developing mental health services for children, birth to 5 years of age. The Division of Children and Youth Services Director will attend and participate in meetings of the Statewide Early Childhood Advisory Council (SECAC). Minutes of the meetings will be available upon request.
Baseline Measurement	In FY 2014, 5 CMHCs (Regions 8, 10, 12, 14, and 15) provided 12 specialized day treatment programs for children ages 3–5 years. Technical assistance by the DMH Division of Children and Youth staff was provided to all CMHCs providing this service.
First Year Target/Outcome Measurement	In FY 2016, all providers developing mental health services for infants and children, birth to 5 years of age, will receive technical assistance when requested.
Second Year Target/Outcome Measurement	In FY 2017, all providers developing mental health services for infants and children, birth to 5 years of age, will receive technical assistance when requested.
Description of Data	The DMH Division of Children and Youth Services monthly staffing report forms
Criteria	Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

Priority Area 1	Comprehensive Community-Based Mental Health Systems for Children and Youth with SED
Goal: 3	To continue availability of school-based general outpatient mental health services (other than day treatment)
Strategies	Continued availability of school-based general outpatient services to children with serious emotional disturbance and their families will be provided. Current DMH Operational Standards require all CMHCs to offer and if accepted, maintain interagency agreements with each local school district in their region, which outline the provision of school-based services to be provided by the CMHCs.
Indicator	Number of regional CMHCs through which general outpatient services for children with serious emotional disturbance are made available (offered) to schools (Offered by 14 CMHC regions)
Baseline Measurement	In FY 2014, a total of 17,325 children were reported as having received school-based outpatient services through the CMHCs. CMHCs provided mental health services in 801 school-based sites. School-based general outpatient mental health services were provided by 495 school-based outpatient therapists.
First Year Target/Outcome Measurement	In FY 2016, all 14 CMHCs will offer school-based general outpatient mental health services.
Second Year Target/Outcome Measurement	In FY 2017, all 14 CMHCs will offer school-based general outpatient mental health services.
Description of Data	The DMH Division of Children and Youth Services records/reporting; Annual State Plan Survey
Criteria	Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

Priority Area 1	Comprehensive Community-Based Mental Health Systems for Children and Youth with SED
Goal: 4	To continue to provide funding and/or DMH certification for therapeutic foster care (TFC) homes that serve children/youth with SED to further develop community-based residential mental health treatment services for children with SED
Strategies	The DMH will continue to provide funding to the evidence-based therapeutic foster care program operated by Catholic Charities, Inc. Additionally, DMH will provide funding to Mississippi Children's Homes Services (MCHS) to support their therapeutic foster care program**.** The DMH Division of Children/Youth Services also plans to continue to make available technical assistance to providers of therapeutic foster care services, including providers certified, but not funded by the DMH.
Indicator	The number of children receiving therapeutic foster care services, based on evidence-based practice, provided with the DMH funding support (i.e., through Catholic Charities, Inc. and MCHS)
Baseline Measurement	In FY 2014, the DMH continued to make funding available to Catholic Charities, Inc. to help support licensed therapeutic foster care homes. Catholic Charities provided therapeutic foster care to 31 youth in FY 2014. In 2015, the DMH made funding available for another therapeutic foster care provider, Mississippi Children's Homes Services (MCHS), to help support the development of licensed TFC homes**.** Additionally, 5 nonprofit private providers certified but not funded by the DMH, provided therapeutic foster care services to a total of 138 youth.
First Year Target/Outcome Measurement	In 2016, 24 children/youth will receive therapeutic foster care services through Catholic Charities, Inc., funded by the DMH.
Second Year Target/Outcome Measurement	In 2017, 24 children/youth will receive therapeutic foster care services through Catholic Charities, Inc., funded by the DMH.
Description of Data	Division of Children/Youth Services Program grant reports
Criteria	Management Systems

***Footnote:** Therapeutic Foster Care (TFC) Services continue to be an important community based component, particularly for children with serious emotional disturbance in the custody of the Department of Human Services. The model utilized in Mississippi employs trained therapeutic foster parents with only 1 child or youth with SED placed in each home. The DMH continues to make funding available to Catholic Charities, Inc. to help support 24 therapeutic foster care homes. In FY 2015, funding was provided to Mississippi Children's Homes Services to help support 17 therapeutic foster care homes. Additional youth are served in therapeutic foster care funded by other agencies, including the Department of Human Services.

Priority Area 1	Comprehensive Community-Based Mental Health Systems for Children and Youth with SED
Goal: 5	The DMH funding will continue to be made available for 9 therapeutic group homes for children and youth with serious emotional disturbance.

Strategies	The DMH will continue to provide funding to support therapeutic group homes. Therapeutic group homes typically include an array of therapeutic interventions, such as individual, group and/or family therapy and individualized behavior management programs.
Indicator	The number of therapeutic group homes for which the DMH provides funding support – 9
Baseline Measurement	In FY 2014, the DMH continued to make funding available for 9 therapeutic group homes. A total of 183 children and youth with serious emotional disturbances were served by therapeutic group homes receiving funding from the DMH.
First Year Target/Outcome Measurement	In FY 2016, the DMH will make funding available for 9 therapeutic group homes.
Second Year Target/Outcome Measurement	In FY 2017, the DMH will make funding available for 9 therapeutic group homes.
Description of Data	Division of Children/Youth Services Residential Monthly Summary Forms/Grant Proposals from the existing DMH-funded therapeutic group home providers
Criteria	Management Systems

Priority Area 1	Comprehensive Community-Based Mental Health Systems for Children and Youth with SED
Goal: 6	To evaluate children with serious emotional disturbance who receive substantial public assistance for Community Support Services and to offer these services to families
Strategies	Evaluation services will be provided to determine the need for Community Support Services, as documented in the record, for children with serious emotional disturbance who are receiving Medicaid and are served through the public community mental health system.
Indicator	Number of children with serious emotional disturbances who receive Community Support Services
Baseline Measurement	In FY 2014, 13,206 children and youth with serious emotional disturbance received Community Support Services from the CMHCs. Of the 13,206 children and youth receiving this service, 11,993 receive substantial public assistance Medicaid. In FY 2014, 284 CMHC Community Support Specialists provided services to children/youth with SED.
First Year Target/Outcome Measurement	In FY 2016, 10,000 children/youth with serious emotional disturbance will receive Community Support Services.
Second Year Target/Outcome Measurement	In FY 2017, 10,000 children/youth with serious emotional disturbance will receive Community Support Services.
Description of Data	Compliance will be monitored through the established on-site review/monitoring process
Criteria	Mental Health System Data and Epidemiology

Priority Area 1	Comprehensive Community-Based Mental Health Systems for Children and Youth with SED
Goal: 7	To continue to make funding available for Crisis Stabilization Services for youth with serious emotional disturbance or behavioral disorders who are in crisis, and who otherwise are imminently at-risk of out-of-home/community placement
Strategy	The DMH will continue funding to Catholic Charities for a comprehensive Crisis Stabilization Program for youth with serious emotional disturbance or behavioral disorders and who otherwise are imminently at-risk of out-of-home/community placement.
Indicator	Number of youth served in the program
Baseline Measurement	In FY 2014, 77 children/youth were served in the Crisis Stabilization Program.
First Year Target/Outcome Measurement	In FY 2016, 70 children/youth will be served in the Crisis Stabilization Program.
Second Year Target/Outcome Measurement	In FY 2017, 70 children/youth will be served in the Crisis Stabilization Program.
Description of Data	Division of Children/Youth Service Crisis Intervention Program Monthly Summary Forms and Grant Proposals for Catholic Charities
Criteria	Management Systems

Priority Area 1	Comprehensive Community-Based Mental Health Systems for Children and Youth with SED
Goal: 8	To continue funds for specialized intensive outpatient services of 5 CMHCs
Strategy	The DMH will continue funding specialized intensive outpatient programs – 5
Indicator	The number of programs that receive DMH funding for specialized intensive outpatient programs – 5
Baseline Measurement	In FY 2014, the DMH continued to provide funding for seven (7) specialized outpatient intensive crisis intervention projects: Region 3 CMHC served 75 youth; Region 4 served 151 youth; Region 7 served 28 youth; Region 8 served 2,563 youth; Region 12 served 51 youth; Region 13 served 403 youth; and Region 15 served 39 youth.
First Year Target/Outcome Measurement	In FY 2016, the DMH will provide funding for 5 specialized intensive outpatient programs.
Second Year Target/Outcome Measurement	In FY 2017, the DMH will provide funding for 5 specialized intensive outpatient programs.
Description of Data	Division of Children/Youth Services Crisis Monthly Summary Forms/Grant Proposals for the specialized programs/monthly cash Requests
Criteria	Management Systems

Priority Area 1	Comprehensive Community-Based Mental Health Systems for Children and Youth with SED
Goal: 9	To maintain provision of community-based services to children with serious emotional disturbance
Strategy	The DMH will continue to collect data on the total number of children with serious emotional disturbance served through community mental health centers and other nonprofit providers.
Indicator	The total number of children with serious emotional disturbance served through community mental health centers and other nonprofit providers of services to children with serious emotional disturbance (26,250 each year). It should be noted that the number of youth targeted to be served in the following objective includes only youth with serious emotional disturbances served through the public community mental health system, which are a subset of the number of youth with any mental illness accessing services in the public community and inpatient system, reported in the NOM.
Baseline Measurement	In FY 2014, 31,439 children and youth with SED were reported to have been served through the regional community mental health centers, and 2,755 children and youth with SED were reported to have been served through other nonprofit providers certified and received funding from the DMH; a total of 34,194 children and youth with SED were served by the public community mental health system. There may also be some duplication in totals across the CMHC and other nonprofit programs.
First Year Target/Outcome Measurement	In FY 2016, 26,250 children/youth with SED will be served through community mental health centers and other non-profit providers of mental health services.
Second Year Target/Outcome Measurement	In FY 2017, 26,250 children/youth with SED will be served through community mental health centers and other non-profit providers of mental health services.
Description of Data	Annual State Plan Survey; community mental health service provider data.
Criteria	Mental Health System Data and Epidemiology

Priority Area 1	Comprehensive Community-Based Mental Health Systems for Children and Youth with SED
Goal: 10	To improve school attendance for those children and families served by CMHCs
Strategy	School-based therapists employed by the CMHCs will continue to offer and provide as requested mental health services in the local schools, including school-based outpatient therapy and school-based day treatment programs, as described in the State Plan.
Indicator	Interagency agreements between schools and CMHCs providing school-based Services will be verified on monitoring visits by the DMH. Data from URS Table will also be obtained.
Baseline Measurement	In FY 2014, at least 1 outpatient therapist was offered to every public school district in the region served by the CMHC
First Year Target/Outcome	In FY 2016, every public school district in the state will be offered outpatient therapy services by the CMHCs.

Measurement	
Second Year Target/Outcome Measurement	In FY 2017, every public school district in the state will be offered outpatient therapy services by the CMHCs.
Description of Data	Interagency agreements between schools and CMHCs providing school-based services; site visit documentation; data submitted by CMHCs into the CDR.
Criteria	Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

Priority Area 1	Comprehensive Community-Based Mental Health Systems for Children and Youth with SED
Goal: 11	To continue funding existing programs that serve children who are homeless/potentially homeless due to a variety of factors such as domestic violence, lack of resources/supports, lack of healthcare, or parents' mental illness
Strategy	The DMH will continue to provide funding to the MAP Teams, specialized intensive outpatient programs, intervention programs, therapeutic foster care programs, crisis stabilization, and therapeutic group homes.
Indicator	The number of funded programs that serve children who are homeless/potentially homeless through this specialized program – 16
Baseline Measurement	In 2014, the DMH provided funding to 19 programs, including MAP Teams, intensive crisis intervention programs, and therapeutic foster care and group homes, that serve children/youth who are homeless/potentially homeless due to a variety of factors such as domestic violence, lack of resources/supports, lack of healthcare, or parents' mental illness.
First Year Target/Outcome Measurement	In FY 2016, the DMH will provide funding to 16 programs that serve children/youth that are homeless/potentially homeless due to a variety of factors such as domestic violence, lack of resources/supports, lack of healthcare, or parents' mental illness.
Second Year Target/Outcome Measurement	In FY 2017, the DMH will provide funding to 16 programs that serve children/youth that are homeless/potentially homeless due to a variety of factors such as domestic violence, lack of resources/supports, lack of healthcare, or parents' mental illness.
Description of Data	Grant proposal for existing programs. These funded programs are required to submit monthly data on the number of children served (targeted above) including the number of children with serious emotional disturbance.
Criteria	Management Systems

Priority Area 1	Comprehensive Community-Based Mental Health Systems for Children and Youth with SED
Goal: 12	To continue to make available technical assistance and/or certification visits in expanding school-based children's mental health services
Strategy	The DMH Division of Children and Youth Services will continue to provide technical assistance regarding the availability of and access to

	school-based services across CMHC regions. The DMH will continue efforts to assess needs and plan strategies to meet the needs of children and youth and their families in rural areas.
Indicator	Number of community mental health centers receiving technical assistance and/or certification visits for program expansion in the schools – 12 or 6 per year
Baseline Measurement	In FY 2014, 12 CMHC regions received technical assistance and/or certification visits from the DMH regarding the expansion of school-based services (Regions 1, 2, 3, 4, 6, 8, 10, 11, 12, 13, 14, and 15).
First Year Target/Outcome Measurement	In FY 2016, 6 CMHC regions will receive technical assistance from the DMH regarding the expansion of school-based services.
Second Year Target/Outcome Measurement	In FY 2017, 6 CMHC regions will receive technical assistance from the DMH regarding the expansion of school-based services.
Description of Data	Monthly Division Activities Report
Criteria	Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

Priority Area 1	Comprehensive Community-Based Mental Health Systems for Children and Youth with SED
Goal: 13	To further enhance service development and quality of service delivery to minority populations of children and youth with severe behavioral and emotional disorders
Strategy	The DMH requires CMHCs and other DMH-certified programs to offer cultural diversity and/or sensitivity training in accordance with the DMH Operational Standards and/or provide cultural competency training to employees.
Indicator	Number of training sessions presented for children/youth service providers that address cultural diversity awareness and/or sensitivity
Baseline Measurement	In FY 2014, 4 cultural diversity awareness and/or sensibility trainings were conducted: on July 11, 2013, for staff at the Mississippi Department of Human Services; on September 16, 2014, for participants at a social work conference; on October 3, 2013, for a statewide training offered through DREAM of Jackson, on October 16, 2013 for staff at Region 9/Hinds Behavioral Health Services, and for staff at Warren-Yazoo Mental Health Services March 26-27, 2014.
First Year Target/Outcome Measurement	In FY 2016, the DMH staff will sponsor or facilitate 3 trainings for children/youth service providers that address cultural diversity awareness and/or sensibility.
Second Year Target/Outcome Measurement	In FY 2017, the DMH staff will sponsor or facilitate 3 trainings for children/youth service providers that address cultural diversity awareness and/or sensibility.
Description of Data	The DMH Division of Children/Youth Services monthly staffing report forms and training sessions or workshop agendas.
Criteria	Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

Priority Area 1	Comprehensive Community-Based Mental Health Systems for Children and Youth with SED
Goal: 14	To improve cultural relevance of mental health services through identification of issues by the Multicultural Task Force
Strategy	Meetings/activities by the Multicultural Task Force will be conducted. The ongoing functioning of the Multicultural Task Force has been incorporated in the State Plan to identify and address any issues relevant to persons in minority groups in providing quality community mental health services and to improve the cultural awareness and sensitivity of staff working in the mental health system. The Day of Diversity coordinated by the Multicultural Task Force includes participation by local agencies, family members, and community members in the CMHCs' regional areas. The Multicultural Task Force will develop a disparity statement that will address equity in mental health services and supports.
Indicator	The number of meetings of the Multicultural Task Force (at least 2 per year) with a report to the Mississippi State Mental Health Planning and Advisory Council when requested or as needed.
Baseline Measurement	In FY 2014, the Multicultural Task Force met on October 18, 2013, on February 11, 2014, and on May 2, 2014. The task force organized the Day of Diversity which was held on October 13, 2014. The task force members also participated in the National Minority Mental Health Awareness events throughout the state in the month of July. A report to the Mississippi State Mental Health Planning and Advisory Council regarding the activities of the task force occurred on November 13, 2014.
First Year Target/Outcome Measurement	In FY 2016, the Multicultural Task Force will have at least 2 meetings.
Second Year Target/Outcome Measurement	In FY 2017, the Multicultural Task Force will have at least 2 meetings.
Description of Data	Minutes of task force meetings and minutes of Planning Council meeting(s) at which task force report(s) are made
Criteria	Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

Priority Area 1	Comprehensive Community-Based Mental Health Systems for Children and Youth with SED
Goal: 15	To guide the implementation of the Cultural Competency Implementation Workgroup to ensure culturally competency services are provided to individuals receiving services
Strategy	The Cultural Competency Committee/Workgroup will guide the implementation of the Cultural Competency Plan.
Indicator	Meeting/activity by the Cultural Competency Workgroup
Baseline Measurement	In FY 2014, the Cultural Competency Workgroup met on January 17, 2014, on April 16, 2014, and on May 16, 2014. The workgroup consists of staff from the DMH Division of Adult Services, the DMH

	Division of Children and Youth Services, the DMH Division of Information/Technology Services, the DMH Bureau of Alcohol and Drug Services, and the DMH Office of Incident Management. In these meetings, the workgroup revised the Strategic Planning map and updated the goals.
First Year Target/Outcome Measurement	In FY 2016, the Cultural Competency Workgroup will have 3 meetings.
Second Year Target/Outcome Measurement	In FY 2017, the Cultural Competency Workgroup will have 3 meetings.
Description of Data	Minutes of the workgroup meetings
Criteria	Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

Priority Area 1	Comprehensive Community-Based Mental Health Systems for Children and Youth with SED
Goal: 16	To address the stigma associated with mental illness through a mental illness awareness campaign
Strategy	The DMH will continue to lead a statewide public education effort to counter stigma and bring down barriers that keep people from seeking treatment by leading statewide efforts in the mental illness awareness campaign.
Indicator	Estimated number of individuals reached through educational/media campaign, based on tracking the number of printed materials including press releases, newspaper clippings, brochures and flyers (200,000). The DMH will also track the number of live interviews and presentations.
Baseline Measurement	In FY 2014, approximately 137 presentations addressing stigma were conducted statewide. Presentations occurred in junior high and high schools, churches, colleges, schools of nursing, and many other groups and organizations. More than 25,000 brochures and 1,000 potty posters were distributed to dispel stigma concerning mental illness in our state in FY 2014.
First Year Target/Outcome Measurement	In FY 2016, the DMH will continue to address the stigma associated with mental illness through a mental illness awareness campaign.
Second Year Target/Outcome Measurement	In FY 2017, the DMH will continue to address the stigma associated with mental illness through a mental illness awareness campaign.
Description of Data	Media and educational presentation tracking data maintained by the DMH Director of Public Information
Criteria	Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

State Priority 2: Interagency Collaboration for Children and Youth with SED

Interagency collaboration and coordination of activities is a major focus of the Department, the Division of Children and Youth Services and the Planning Council, and exists at the state level and in local and regional areas, encompassing needs assessment, service planning, strategy development, program development, and service delivery. Examples of major initiatives explained below are the Interagency Coordinating Council for Children and Youth (ICCCY) and the Interagency System of Care Council (ISCC), the State-Level Interagency Case Review/ MAP Team, the Making A Plan (MAP) Teams, the Executive Steering Committee (ESC) of the Statewide Affinity Group (SWAG), and participation in a variety of state-level interagency councils and committees.

The executive-level Interagency Coordinating Council for Children and Youth (ICCCY) and mid-level Interagency System of Care Council (ISCC), work together to advise the Interagency Coordinating Council in order to establish a statewide system of local Making a Plan (MAP) Teams. (For membership see Priority 1).

The State-Level Interagency Case Review/MAP Team, which operates under an interagency agreement, includes representatives from the state of Mississippi: Department of Mental Health, Department of Human Services, Division of Medicaid, Department of Health, Department of Education, Department of Rehabilitation Services, the Attorney General's Office, and Families As Allies for Children's Mental Health, Inc. The team meets once a month and on an as-needed basis to review cases and/or discuss other issues relevant to children's mental health services. The team targets youth with serious emotional disturbance or co-occurring disorders of SED and Intellectual/Developmental Disabilities who need the specialized or support services of two or more agencies in-state and who are at imminent risk of out-of-home or out-of-state placement. The youth reviewed by the team typically have a history of numerous out-of-home psychiatric treatments, numerous interruptions in delivery of services, and appear to have exhausted all available services/resources in the community and/or in the state. Youth from communities in which there is no local MAP team with funding have priority.

Local Making A Plan (MAP) Teams develop family-driven, youth guided plans to meet the needs of children and youth referred while building on the strengths of the child/youth and their family. Key to the team's functioning is the active participation in the assessment, planning and/or service delivery process by family members, the community mental health service providers, county human services (family and children's social services) staff, local school staff, as well as staff from county youth services (juvenile justice), health department and rehabilitation services. Youth leaders, ministers or other representatives of children/youth or family service organizations may also participate in the planning or service implementation process. This wraparound approach to service planning has led to the development of local Making A Plan (MAP) Teams in 14 community mental health regions across the state. Sixty three counties either have a MAP Team or access to one, and all 53 MAP Teams continue to operate statewide and have accessibility to flexible funds.

The Executive Steering Committee provides oversight and accountability of MTOP's activities toward meeting requirements of the Cooperative Agreement with the Substance Abuse and Mental Health Services Administration (SAMHSA). In addition to other tasks, this committee meets monthly and participates on the subcommittees of the Statewide Affinity Group, ensures that effective support and technical assistance are provided to the MTOP sites, votes on budget issues, and advocates on a youth's behalf or on behalf of other youth and families who may not have

found their voice. Membership of the committee includes, but is not limited to, DMH representation, the local-level MTOP Project Coordinators, a representative from three family advocacy networks, a faith-based organization, a juvenile justice entity, the Attorney General's Office, the MS Department of Human Services, the MS Department of Education, the Department of Vocational Rehabilitation, a continuous quality improvement/evaluation entity, a post-secondary education entity, a community college representative, Certified Peer Support Specialist, two youth, and two family/parent representatives.

The DMH staff participates in a variety of state-level interagency collaboration activities and provides support for interagency collaboration at the local level in the 14 CMHC regions. These efforts involve staff of other key child service agencies or nonprofit organizations at the state and local levels and representatives of parent/family organizations for children with serious emotional disturbance. Notification of education/training activities offered by the DMH Division of Children and Youth Services will be distributed to programs serving runaway/homeless youth made known to the DMH through other child service agencies (primarily the Department of Human Services).

Priority Area 2	Interagency Collaboration for Children and Youth with SED
Goal: 1	To provide mental health representation on the executive-level Interagency Coordination Council for Children and Youth (ICCCY) and the mid-management level Interagency System of Care Council (ISCC), as required by recent legislation
Strategy	The DMH will continue to be represented on the executive-level ICCCY and the mid-level Interagency System of Care Council, in accordance with House Bill 1529 and continue participation in activities by both Councils to facilitate the development/maintenance of interagency collaboration (at the state, regional and local levels).
Indicator	Minutes of meetings and related documentation of attendance by the DMH representatives at meetings scheduled in FY 2016 and FY 2017
Baseline Measurement	In 2014, the ISCC met on July 29, 2014, and December 3, 2014, to discuss new System of Care projects, coordinate multi-agency trainings/conferences, review data from MAP Team quarterly reports, discuss intensive home and community-based services, and items for the 2015 ICCCY meeting agenda.
First Year Target/Outcome Measurement	In FY 2016, agendas and notes of the ICCCY and mid-level Interagency System of Care Council meetings will be recorded.
Second Year Target/Outcome Measurement	In FY 2017, agendas and notes of the ICCCY and mid-level Interagency System of Care Council meetings will be recorded.
Description of Data	Agendas and notes of the ICCCY and the Division of Children and Youth Services Monthly Calendar and minutes of the mid-level Interagency System of Care Council and revised Interagency Agreement
Criteria	Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

***Footnote:** Additional members added to the ICCCY include a representative from the Attorney General's Office, a MAP Team Coordinator, a parent of youth with SED, a youth, child psychiatrist, a faculty member from the University of MS Medical Center, Director of The ARC of MS, and an early childhood development expert.

Priority Area 2	Interagency Collaboration for Children and Youth with SED
Goal: 2	To continue operation of the State-Level Interagency Case Review/MAP Team for the most difficult to serve youth with serious emotional disturbance who need services of multiple agencies
Strategy	The State-Level Interagency Planning and Case Review Team will continue to meet monthly to review cases and to address the needs of youth with particularly severe or complex issues. The team targets those "most difficult to serve" youth with serious emotional disturbance or co-occurring disorders of SED and Intellectual/Developmental Disabilities who need the specialized or support services of two or more agencies in-state and who are at imminent risk of out-of-home (in-state) or out-of-state placement. The youth reviewed by the team typically have a history of more than one out-of-home psychiatric treatment and appear to have exhausted all available services/resources in the community and/or in the state. The team develops a recommended resource identification and accessibility plan, which might include formal existing services and informal supports; monitors and tracks implementation of the recommended service plan and the status of the child/youth; and, uses information about the availability of needed services, success of services, and other pertinent information in planning efforts.
Indicator	Continued meeting of the State-Level Interagency Planning and Case Review Team to review cases and number of children served using this funding for wraparound services
Baseline Measurement	In FY 2014, the State-Level Case Review/MAP Team met the second Thursday of each month (monthly) at the Mississippi Department of Human Services to review referred cases and provide follow-up on cases previously reviewed.
First Year Target/Outcome Measurement	In FY 2016, the State-Level Case Review/MAP Team will meet monthly to review referred cases and provide follow-up on cases previously reviewed.
Second Year Target/Outcome Measurement	In FY 2017, the State-Level Case Review/MAP Team will meet monthly to review referred cases and provide follow-up on cases previously reviewed.
Description of Data	Monthly Division Activities Report and State-Level Case Review Team Staffing forms.
Criteria	Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

Priority Area 2	Interagency Collaboration for Children and Youth with SED
Goal: 3	To continue to provide support and technical assistance in the implementation of Making A Plan (MAP) Teams and to further assist in the wrap-around approach to provide services and supports for children/youth with SED and their families
Strategy	The DMH Division of Children and Youth Services will continue to provide support and technical assistance to MAP Teams as requested and/or needed and will continue to coordinate meetings with MAP team coordinators to which representatives from the behavioral health center's child/adolescent units and the Department of Human Services

	representatives are invited.
Indicator	Provision of MAP Team Coordinators Meetings for networking among MAP teams.
Baseline Measurement	In FY 2014, the Division of Children and Youth Services Director had a statewide meeting with the coordinators of local MAP Teams and the CMHC Children's Services Coordinators on January 17, 2014. The following items were discussed: RFA Guidelines, upcoming conferences and opportunities for continuing education and training, Wraparound Facilitation trainings, and flexible funding. MAP Team 101 Training was held October 22-23, 2013, for new MAP Team Coordinators. The DMH Division of Children and Youth staff attended MAP Teams meetings at every MAP Team across the state in all of the CMHC regions to provide technical assistance. Monitoring forms were utilized to determine the need for future training and provide information and assistance if needed.
First Year Target/Outcome Measurement	In FY 2016, MAP Team Coordinators Meetings will be scheduled and Division of Children and Youth staff will provide technical assistance visits to local MAP Teams when requested.
Second Year Target/Outcome Measurement	In FY 2017, MAP Team Coordinators Meetings will be scheduled and Division of Children and Youth staff will provide technical assistance visits to local MAP Teams when requested.
Description of Data	Monthly Division Activities Report and minutes of statewide MAP Team Coordinators Meetings.
Criteria	Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

Priority Area 2	Interagency Collaboration for Children and Youth with SED
Goal: 4	To continue to make available funding for Making A Plan (MAP) Teams
Strategy	The DMH will continue to fund MAP Teams.
Indicator	Number of MAP teams that receive or have access to flexible funding through the DMH – 53
Baseline Measurement	In FY 2014, 1 DMH certified provider in each of the 15 CMHC regions received a grant from the DMH to provide flexible funds for MAP Teams. 63 counties either have a MAP Team or access to a MAP Team. All 50 MAP Teams continued to operate and had access to flexible funds. Region 8 continued to receive additional funding for children with Fetal Alcohol Spectrum Disorders. During FY 2014, MAP Teams served 1,504 children and youth.
First Year Target/Outcome Measurement	In FY 2016, MAP Teams will continue to operate and have access to flexible funds.
Second Year Target/Outcome Measurement	In FY 2017, MAP Teams will continue to operate and have access to flexible funds.
Description of Data	Documentation of grant awards, monthly MAP team reports, monthly cash requests
Criteria	Management Systems

Priority Area 2	Interagency Collaboration for Children and Youth with SED
Goal: 5	To continue to provide information to schools on recognizing those children and youth most at risk for having a serious emotional disturbance or mental illness and on resources available across the state, including services provided by CMHCs
Strategy	The DMH will make available informational materials and technical assistance on serious emotional disturbance to CMHCs to provide to local school districts and other individuals/entities upon request.
Indicator	The number of local schools to which the CMHCs make available informational materials or technical assistance will be documented and available to the DMH, Division of Children/Youth, upon request
Baseline Measurement	In FY 2014, informational materials and technical assistance were provided to 785 local schools by community mental health centers. Topics included available services for children with SED; behavior modification and intervention; Mental Health First Aid; A.S.I.S.T.; alcohol and drug prevention; healthy relationships; crisis management training/MANDT Crisis Intervention Training; mental health diagnoses and identification of signs and symptoms of disorders; medication safety, compliance and side effects; confidentiality; parenting issues; referral process for services; bullying, truancy, anger management, suicide prevention and preventing violence in the schools.
First Year Target/Outcome Measurement	In FY 2016, informational materials and technical assistance will be provided to local school districts by CMHCs as requested.
Second Year Target/Outcome Measurement	In FY 2017, informational materials and technical assistance will be provided to local school districts by CMHCs as requested.
Description of Data	Annual State Plan Survey
Criteria	Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

Priority Area 2	Interagency Collaboration for Children and Youth with SED
Goal:6	To continue support for and participation in interagency collaboration activities and other key activities related to infrastructure building as well as make available technical assistance for this development at the state and local levels
Strategy	The DMH Children and Youth Services staff will continue to participate on state-level interagency councils or committees. Interagency collaboration at the state and local levels in planning and training is necessary to develop a more integrated system and to improve continuity of care.
Indicator	Number of state-level interagency councils/committees on which the DMH Division of Children and Youth Services staff participate
Baseline Measurement	In FY 2014, the DMH Division of Children and Youth staff participated on 22 state-level interagency councils/committees.
First Year Target/Outcome	In FY 2016, the DMH Division of Children and Youth staff will participate on at least 15 state-level interagency councils/committees.

Measurement	
Second Year Target/Outcome Measurement	In FY 2017, the DMH Division of Children and Youth staff will participate on at least 15 state-level interagency councils/committees.
Description of Data	Monthly Division Activities Report
Criteria	Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

Priority Area 2	Interagency Collaboration for Children and Youth with SED
Goal:7	To provide funding for the State-Level Interagency Case Review/MAP Team to purchase critical services and/or supports identified as needed for targeted children/youth with SED reviewed by the team
Strategy	The DMH Division of Children and Youth Services will make funding available to the State-Level Interagency Case Review/MAP Team to provide services to youth identified through the team**.** The state-level team facilitates a wraparound purchase of services and support process for children/youth at risk of being inappropriately placed out-of-home. Youth from communities in which there is no local MAP team with funding have priority.
Indicator	Number of children served using this funding for wraparound services
Baseline Measurement	In FY 2014, the State-Level Case Review Team reviewed 11 new cases and provided follow-up on 8 cases. Of the new cases, 1 youth was diagnosed with Impulse Control Disorder, 1 with Post Traumatic Stress Disorder, 4 with Mood Disorder, NOS, 1 with Conduct Disorder, 3 with Oppositional Defiant Disorder, and 1 with Depression as their primary diagnoses. Of the 11 youth referred to the State-Level Case Review Team, 2 youth had a diagnosis of Mild Mental Retardation and 1 youth had a diagnosis of Moderate Mental Retardation. One of the children referred also had a diagnosis of Autism. Of the 11 cases reviewed, 3 youth were transitional age. During this time period, 1 child returned home from an in-state facility.
First Year Target/Outcome Measurement	In FY 2016, the State-Level Case Review/MAP Team will review cases.
Second Year Target/Outcome Measurement	In FY 2016, the State-Level Case Review/MAP Team will review cases.
Description of Data	Documentation of grant award on file at DMH; monthly cash requests
Criteria	Management Systems

State Priority 3: Expansion of System of Care for Children and Youth with SED

Children and Youth Services staff continues to participate in interagency meetings and conferences that provide opportunities for increasing awareness across the service system of available children's mental health services. They also continue to disseminate the CYS resource directory through the agency website as well as provide educational materials to individuals at conferences and meetings, the general public and in particular to schools, to facilitate the identification and referral to services of youth with serious emotional disturbances.

Provision of Evidence-Based Practices

Wraparound Initiatives in Mississippi

The Division of Children and Youth Services partnered with the Division of Medicaid's MYPAC Program to begin state-wide training on Wraparound Facilitation for providers of children/youth services including the community mental health centers, two non-profit organizations, parents and social workers. Both agencies assisted in the development of the Mississippi Wraparound Initiative (MWI) established through the University of Southern Mississippi's School of Social Work. The MWI utilizes the University of Maryland's Innovation's Institute training model which includes a 3-day Wraparound 101 course, 1-day Advanced Wraparound, and a 12-18 month process for Coach/Supervision Certification.

Priority Area 3	Expansion of System of Care for Children and Youth with SED
Goal:1	To promote and provide funding assistance for the use of evidence-based practices in the community mental health services system for children with serious emotional disturbances
Strategy	The Division of Children and Youth Services will continue to provide technical assistance to monitor the implementation of evidence-based practices. Initiatives to promote implementation of evidence-based practices for youth and families include the Collaborative Learning for Trauma-Focused Cognitive Behavior Therapy (TF-CBT) and Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) described in the Plan will also continue.
Indicator	The number of evidence-based practices implemented (with the DMH funding support) for children with serious emotional disturbances; the number of therapists and staff trained
Baseline Measurement	In FY 2014, CMHC Regions 2, 3, 6, 8, and 9 and staff from the two DMH operated hospital units serving children and youth participated in a Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) Learning Community training 40 therapists, including 10 supervisors.
First Year Target/Outcome Measurement	In FY 2016, the DMH will continue to promote and provide funding assistance for the use of evidence-based practices in the community mental health services system for children/youth with serious emotional disturbance.
Second Year Target/Outcome Measurement	In FY 2017, the DMH will continue to promote and provide funding assistance for the use of evidence-based practices in the community mental health services system for children/youth with serious

	emotional disturbance.
Description of Data	Division of Children/Youth Services Program grant reports
Criteria	Management Systems

Priority Area 3	Expansion of System of Care for Children and Youth with SED
Goal:2	To co-sponsor statewide conferences and/or trainings on the System of Care for providers of mental health services, education services, rehabilitation, human services (child welfare), youth/juvenile justice, physical primary health, and families
Strategy	The DMH Division of Children and Youth will continue to provide support to statewide conferences and/or trainings for children's mental health service providers addressing system of care issues for participants from local and state child/family service agencies and families of children/youth with SED.
Indicator	The number of statewide conferences and/or trainings sponsored or co-sponsored by the Division of Children & Youth Services – 4
Baseline Measurement	In FY 2014, the DMH Division of Children and Youth Services served as a primary sponsor of the Annual Lookin' to the Future Conference attended by social workers, mental health counselors, foster families, and youth in therapeutic foster care. This conference occurred in June 2014. In August 2013, the Division of Children and Youth services co-sponsored the Annual Drop-Out Prevention Conference. In October 2014, the Division of Children and Youth co-sponsored the 30th Annual Joint MH/IDD Conference. Finally, in April 2014, the Division of Children and Youth co-sponsored the 7th Annual Mississippi School for Addictions Professionals.
First Year Target/Outcome Measurement	In FY 2016, the DMH will sponsor or co-sponsor 2 statewide conferences on the System of Care.
Second Year Target/Outcome Measurement	In FY 2017, the DMH will sponsor or co-sponsor 2 statewide conferences on the System of Care.
Description of Data	Registration Forms for the conferences; final conference reports
Criteria	Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

Priority Area 3	Expansion of System of Care for Children and Youth with SED
Goal:3	To implement high-fidelity Wraparound Facilitation in 6 community mental health provider agencies
Strategy	The DMH will continue to provide funds for training of additional CMHC staff for the 3-day Wraparound 101 course, a 1-day Engagement course and a 12-18 month process for Coach/Supervisor Training utilizing staff from Mississippi's Wraparound Initiative through the University of Southern Mississippi. The Division of Children and Youth Services partners with the Division of Medicaid, MYPAC Program to provide state-wide training on Wraparound for

	providers of children/youth services including the community mental health centers, 2 non-profit organizations, parents and social workers.
Indicator	The number of community mental health provider agencies participating in and implementing Wraparound Facilitation – 6
Baseline Measurement	In FY 2014, CMHC Regions 2, 4, 6, 7, 9, 10, and 14 were certified by the DMH to provide Wraparound Facilitation and continued to participate in coaching and training sessions. Additionally, 3 non-profit providers are certified to provide Wraparound Facilitation, which include Catholic Charities, Inc., Mississippi Children's Homes Services, and Youth Villages.
First Year Target/Outcome Measurement	In FY 2016, the DMH will continue to provide funding to implement the Wraparound Model in 6 community mental health provider agencies.
Second Year Target/Outcome Measurement	In FY 2017, the DMH will continue to provide funding to implement the Wraparound Model in 6 community mental health provider agencies.
Description of Data	Quarterly and mid-year information collected from CMHCs including sign-in sheets for trainings
Criteria	Management Systems

Priority Area 3	Expansion of System of Care for Children and Youth with SED
Goal:4	To expand specialized programs/resources for transition–aged youth, 14–21 years of age who are transitioning from child mental health services to adult mental health services and/or from an institutional setting into the community
Strategy	The Division of Children and Youth Services received a state-wide Children's Mental Health Initiative (System of Care) grant on October 1, 2009, to serve transition–aged youth with SED. This initiative, the Mississippi Transitional Outreach Program (MTOP), is implemented in 3 community mental health centers. In July 2013, the DMH received a 4-year System of Care Implementation Grant to expand the program into 2 additional counties.
Indicator	The number of MTOP local project sites that will develop and provide specialized services/resources for youth and young adults, 14–21 years of age – 5
Baseline Measurement	In FY 2014, CMHC Regions 4, 7, and 10 continued to provide specialized services/resources for youth and young adults ages 14–21 years of age. NFusion IV (Region 4) serves youth and young adults in Alcorn, Tippah, Tishomingo, and Prentiss counties. NFusion VII serves youth and young adults in Winston and Oktibbeha counties, and NFusion X serves Lauderdale County youth and young adults. In addition to these three MTOP local project sites (NFusion), the DMH Division of Children and Youth Services received an expansion grant to replicate the NFusion model to counties in Region 10's catchment area. A fourth site is currently operating and is located in Newton County (MS Project XPand).
First Year	In FY 2016, the 5 MTOP local project sites will continue to expand

Target/Outcome Measurement	specialized programs/resources for transition–aged youth, 14–21 years of age, who are transitioning from children's mental health services to adult mental health services and/or from an institutional setting into the community.
Second Year Target/Outcome Measurement	In FY 2017, the 5 MTOP local project sites will continue to expand specialized programs/resources for transition–aged youth, 14–21 years of age, who are transitioning from children's mental health services to adult mental health services and/or from an institutional setting into the community
Description of Data	DMH monthly program reports, national program and evaluation reports
Criteria	Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

Priority Area 3	Expansion of System of Care for Children and Youth with SED
Goal: 5	To address suicide awareness, prevention and intervention through training sessions or workshops focused on this topic.
Strategy	The DMH staff will conduct training or workshops upon request by mental health centers, universities, community colleges, and other community agencies
Indicator	The number of trainings provided – 4
Baseline Measurement	In FY 2014, Division of Children and Youth Services staff completed 5 suicide awareness/A.S.I.S.T. trainings to members of Mobile Crisis Emergency Response Teams (MCERT) operated by CMHC Regions 1, 2, 3, 6, 7, 8, 9, and 15. Two Division of Children and Youth staff continues to maintain their certification as A.S.I.S.T. Trainers. In March 2014, an additional staff member completed a week long training to become a certified A.S.I.S.T. Trainer.
First Year Target/Outcome Measurement	In FY 2016, 2 suicide awareness, prevention, and intervention trainings will be provided.
Second Year Target/Outcome Measurement	In FY 2017, 2 suicide awareness, prevention, and intervention trainings will be provided.
Description of Data	Monthly Activity Reports
Criteria	Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

State Priority 4: Integrated Services for Children and Youth with SED

Adolescent Offender Programs

The Adolescent Offender Programs, which receive state funding through the Department of Human Services, Division of Youth Services, are designed to be a diversionary program from the state-operated training school. These programs target the areas of the state that have the highest commitment rates to the state training schools. The DMH technical assistance continued to be available to CMHCs/other nonprofit programs for day treatment programs serving adolescent offenders, upon request/as needed.

Initiatives to Assure Transition to Adult Mental Health Services

The Division of Children and Youth Services, the Division of Adult Community Services, and the Bureau of Alcohol and Drug Abuse have made a concerted effort to better address issues of youth transitioning from the child to the adult system, including needs specific to youth in the age group of 18 to 25 years. The Transitional Services Task Force was formed to better identify and plan to assess needs of youth, age 16 to 25 years. This task force, now called the Executive Steering Committee, has focused on expanding the age range of children/youth identified as transitional–age to include children/youth as young as age 14, the age at which children/youth begin to fall out of the system. The Executive Steering Committee includes representatives from a local mental health center that provide specialized outreach programs as well as representatives from the Division of Medicaid, the Office of the Attorney General and the DMH Bureau of Community Services. The Executive Steering Committee has reviewed a mission statement, purpose and goals, and focused on preliminary identification of available services or special initiatives and how to access them for the targeted age group, potential gaps or needs in services, how services could be made more uniform, and model programs. The work of this committee and its members assisted in the development of successful grant applications for a Children's Mental Health Initiative targeting transition–aged youth. First, a 6-year System of Care grant that provides funds for the implementation of 3 additional Transitional Outreach Programs (MTOP) across the state and most recently, a 4-year grant that expands MTOP to 2 additional counties.

Transitional Living Programs: The DMH Division of Children and Youth Services will continue to support services of a provider of a transitional living services program that address the needs of youth with SED, including those in the transition age range of 16 to 21 years. The DMH provides funding to 4 of the 6 DMH certified transitional therapeutic group homes (Rowland, Harden House, and 2 programs operated by Hope Village).

Priority Area 4	Integrated Services for Children and Youth with SED
Goal:1	To reduce involvement of youth with serious emotional disturbances in the juvenile justice system
Strategy	The DMH will continue to provide technical assistance and support for the mental health component in the Adolescent Offender Programs (AOPs) certified by the DMH. The Adolescent Offender Programs, which receive state funding through the Department of Human Services, Division of Youth Services, are designed to be a diversionary program from the state-operated training school. These programs target the areas of the state that have the highest commitment rates to the state training schools.
Indicator	Provision of technical assistance to Adolescent Offender Programs and

	data obtained from the URS Table
Baseline Measurement	In FY 2014, the DMH Division of Children and Youth staff made visits to Adolescent Offender Programs in CMHC Regions 2, 4, 10, 11, and 15 for certification/technical assistance.
First Year Target/Outcome Measurement	In FY 2016, the DMH will continue to provide technical assistance and support for the mental health component in the Adolescent Offender Programs (AOPs) certified by the DMH.
Second Year Target/Outcome Measurement	In FY 2017, the DMH will continue to provide technical assistance and support for the mental health component in the Adolescent Offender Programs (AOPs) certified by the DMH.
Description of Data	Certification reports and Division of Children & Youth Services Monthly activity log (for technical assistance) and data obtained from URS Table.
Criteria	Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

Footnote: From a system perspective, the Uniform Reporting System (URS) data (based on results of the YSS-F from a representative sample of children with serious emotional disturbances receiving services in the public community mental health system, funded and certified by the DMH, on the percentage of parents/caregivers of children/adolescents served by the public community mental health system reporting that their child had been arrested in one year, but was not rearrested in the next year) will also be reviewed**.**

Priority Area 4	Integrated Services for Children and Youth with SED
Goal:2	To continue funding for mental health services for youth in 2 transitional therapeutic group homes and 2 supported living programs for youth in the transition age group (16–21 years of age).
Strategy	The DMH will continue funding 2 transitional living services group homes and 2 supported living programs serving youth with SED and other conduct/behavioral disorders for provision of mental health services.
Indicator	The number of transitional therapeutic group homes and/or supported living programs that will receive funding through the DMH for mental health services – 4
Baseline Measurement	In FY 2014, there were 6 transitional therapeutic group homes certified by the Department of Mental Health: Rowland, Harden House, PALS, PALS II, and Hope Village (2 programs); 4 of the homes received DMH funding support.
First Year Target/Outcome Measurement	In FY 2016, the DMH will continue funding for mental health services for youth in 2 transitional therapeutic group homes and 2 supported living programs for youth in the transition–age group (16–21 years of age).
Second Year Target/Outcome Measurement	In FY 2017, the DMH will continue funding for mental health services for youth in 2 transitional therapeutic group homes and 2 supported living programs for youth in the transition–age group (16–21 years of age).
Description of Data	Grant awards to continue funding to the targeted transitional living services/supported living programs
Criteria	Management Systems

State Priority 5: Recovery Supports

The DMH Strategic Plan sets forth the DMH's vision of having individuals who receive services to have a direct and active role in designing and planning the services they receive as well as evaluating how well the system meets and addresses their expressed needs. Initiatives in the State Plan are designed to facilitate a system that is person-centered and built on the strengths of individuals and their families while meeting their needs for special services. The DMH strives to provide a network of services and recovery supports for persons in need and the opportunity to access appropriate services according to their individual needs/strengths. Underlying these efforts is the belief that all components of the system should be person-driven, family-centered, community-based, results and recovery/resiliency oriented. The Council on Quality and Leadership's Personal Outcome Measures is now the foundation of the Peer Review process. Goal 1 of the DMH Strategic Plan highlights the transformation to a community-based service system. This transformation is woven throughout the entire Strategic Plan; however, this goal emphasizes the development of new and expanded services in the priority areas of crisis services, housing, supported employment, long term community supports and other specialized services. Goal 1 of the Strategic Plan also provides a foundation on which the DMH will build, with collaboration from stakeholders, a seamless community-based service delivery system.

Recovery means something different to everyone. Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Through the Recovery Support Strategic Initiative, SAMHSA has delineated four major dimensions that support a life in recovery:

- Health: overcoming or managing one's disease(s) or symptoms, for example: abstaining from use of alcohol, illicit drugs, and non-prescribed medication if one has an addiction problem; and for everyone in recovery, making informed health choices that support physical and emotional wellbeing.
- Home: a stable and safe place to live:
- Purpose: meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society, *and*
- Community: relationships and social networks that provide support, friendship, love and hope

Youth Education/Support Initiatives

Through MTOP, each program site has developed Youth Leadership and Advocacy Councils. These councils meet on a regular basis to plan for fundraising events, community activities, various trainings and independent skill development. Members of these youth councils have attended and presented at national SOC grant meetings, the Georgetown Training Institutes, and FFCMH annual conferences and trainings.

Priority Area 5	Recovery Supports
Goal:1	To continue to make available funding for family education and family support capabilities
Strategy	Continuation of funding for family education and family support will be made available by the DMH for NAMI-MS.
Indicator	Number of family workshops and training opportunities to be

	provided and/or sponsored by the DMH for NAMI-MS.
Baseline Measurement	In FY 2014, the DMH continued to make funding available for family education and family support. NAMI-MS provided 1 NAMI Basics (Parent to Parent) class with 12 participants and 44 Parent Support Meetings with 193 participants.
First Year Target/Outcome Measurement	In FY 2016, the DMH will continue to make available funding for family education and family support provided by NAMI-MS.
Second Year Target/Outcome Measurement	In FY 2017, the DMH will continue to make available funding for family education and family support provided by NAMI-MS.
Description of Data	Grant awards/monthly cash requests submitted by NAMI-MS
Criteria	Management Systems

Priority Area 5	Recovery Supports
Goal:2	To develop youth support and leadership teams in the current 3 project sites for the Mississippi Transitional Outreach Program (MTOP).
Strategy	The DMH will continue to support and fund the development of youth support and leadership teams in CMHC Regions 4, 7, and 10.
Indicator	Sign-in sheets of the meetings will be available during the year for CMHC Regions 4, 7, and 10.
Baseline Measurement	In FY 2014, Region 7 CMHC (NFusion VII) had 10 Youth Support Meetings and youth participated in 9 Governance Council Meetings. Region 4 CMHC (NFusion IV) had 8 Youth Support Meetings and youth participated in 4 Governance Council Meetings. Region 10 CMHC (NFusion X) had 10 Youth Support Meetings and youth participated in 8 Governance Council Meetings. Region 10 CMHC (Project XPand-Newton County) had 6 Youth Support Meetings and youth participated in 3 Governance Council Meetings. Youth from CMHC Regions 4, 7, and 10 participated on the Executive Steering Committee (ESC), the Governance Council for MTOP and Project XPand. In addition, youth from CMHC Regions 4, 7, and 10 attended the Family and Youth Retreat, which also offered the opportunity to develop leadership skills. The DMH will continue to develop youth support and leadership teams in the current 3 project sites for the Mississippi Transitional Outreach Project.
First Year Target/Outcome Measurement	In FY 2016, the DMH will continue to develop youth support and leadership teams in the current 3 project sites for the Mississippi Transitional Outreach Project.
Second Year Target/Outcome Measurement	In FY 2017, the DMH will continue to develop youth support and leadership teams in the current 3 project sites for the Mississippi Transitional Outreach Project.
Description of Data	The sign-in sheets are provided by the local project coordinators
Criteria	Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

Priority Area 5	Recovery Supports
Goal:3	To continue to make available funding for family education and family support capabilities.
Strategy	Continuation of funding for family education and family support will be made available by the DMH for 2 DMH certified providers.
Indicator	Number of family workshops and training opportunities to be provided and/or sponsored by the 2 funded agencies.
Baseline Measurement	In FY 2014, the DMH continued to make funding available for family education and family support. Mississippi Families As Allies for Children's Mental Health, Inc. made available 42 family education/support groups (Harrison, Hinds, Forrest, and Warren Counties) and provided 15 family workshops and training opportunities involving 225 participants. Additionally, Region 10 was funded for parenting education classes for the parents of children with SED involved in the juvenile detention center and alternative school. The parent education course met 47 times weekly and has served 51 families.
First Year Target/Outcome Measurement	In FY 2016, the DMH will continue to make available funding for family education and family support provided by 2 funded agencies.
Second Year Target/Outcome Measurement	In FY 2017, the DMH will continue to make available funding for family education and family support provided by 2 funded agencies.
Description of Data	Grant awards/monthly cash requests from Mississippi Families As Allies for Children's Mental Health, Inc. and Region 10 CMHC
Criteria	Comprehensive Community-Based Mental Health Systems

Priority Area 5	Recovery Supports
Goal:4	To continue developing a program evaluation system which promotes accountability and improves quality of care in community mental health and substance abuse services
Strategy	The DMH will continue to refine the peer review/quality assurance process for all community mental health programs and services, including substance abuse services, by utilizing the Personal Outcome Measures (POM) interview protocol to measure outcomes of individuals receiving services.
Indicator	Improved access and outcomes of services to individuals receiving services will be reported; number of peer review/site visits will be reported
Baseline Measurement	In FY 2014, there were 170 interviews conducted during 9 POM visits.
First Year Target/Outcome Measurement	In FY 2016, a minimum of 9 POM visits will be conducted.
Second Year Target/Outcome Measurement	In FY 2017, a minimum of 9 POM visits will be conducted.
Description of Data	POM tracking forms, report summaries

Criteria	Comprehensive Community-Based Mental Health Systems

Priority Area 5	Recovery Supports
Goal:5	To promote the empowerment of individuals and families with mental health needs through education, support, and access to mental health services
Strategy	Increase staff, consumers, and their families understanding of topics related to recovery/recovery supports; the DMH Bureaus/Divisions will partner to plan resource/health fairs to educate others about recovery; information about the Mississippi Leadership Academy (MLA) will be made available to consumers with serious mental illness to increase communication and leadership/advocacy skills; continued funding will be made available by the DMH for family education and family support programs/activities (e.g., drop-in centers, NAMI, MLA); and the DMH will promote consumer information sharing and exchange through the MS Mental Health Recovery Social Network website.
Indicator	Number of family education groups and number of family workshops and training opportunities to be provided will be tracked.
Baseline Measurement	In FY 2014, the following trainings were provided: 3 family to family, 1 peer to peer, and 4 conferences focusing on recovery and peer support. Quarterly meetings with the Certified Peer Specialists providing education on meaningful participation and recovery were conducted.
First Year Target/Outcome Measurement	In FY 2016, the number of family education groups, workshops, and training opportunities will be increased.
Second Year Target/Outcome Measurement	In FY 2017, the number of family education groups, workshops, and training opportunities will be increased.
Description of Data	Grant awards/monthly cash requests from service providers will be tracked; documentation/dates of material provided
Criteria	Comprehensive Community-Based Mental Health Systems

Priority Area 5	Recovery Supports
Goal:6	To establish policies and procedures to ensure consumer and family participation in monitoring/evaluating the mental health system through the peer review process
Strategy	The DMH Bureaus and Divisions will develop policies and procedures for the peer review process.
Indicator	The DMH Bureaus and Divisions will develop policies and procedures for the peer review process.
Baseline Measurement	In FY 2014, the DMH developed policies and protocols using personal outcome measures (POM) to ensure consumer and family participation in the peer review process.
First Year Target/Outcome Measurement	In FY 2016, the DMH will continue to utilize consumers, family members, and professionals in the POM process. Using the POMs and Components of Recovery, the DMH will evaluate the

	improvement of people's lives in their home, health, and community.
Second Year Target/Outcome Measurement	In FY 2017, the DMH will continue to utilize consumers, family members, and professionals in the POM process. Using the POMs and Components of Recovery, the DMH will evaluate the improvement of people's lives in their home, health, and community.
Description of Data	The DMH will utilize the Council on Quality and Leadership's (CQL) Personal Outcome Measures (POM) tool to gain information about the level at which service providers are supporting personal outcomes of individuals being served. Policies and procedures and number of POM interviews conducted by consumers and family members will be tracked
Criteria	Comprehensive Community-Based Mental Health Systems

Priority 6: Prevention of Substance Abuse and Mental Illness

Support for Services for Youth with Co-occurring Disorders

The Division of Children and Youth Services and the Bureau of Alcohol and Drug Services collaborate to include sessions on co-occurring disorders in youth at the annual MS School for Addiction Professionals. The Division of Children and Youth staff continues to monitor and provide technical assistance to community-based residential programs funded by the DMH for adolescents with substance abuse problems which also address problems of youth with co-occurring disorders. Staff in both the DMH Bureau of Alcohol and Drug Services and the Division of Children and Youth Services has provided training, information and support to women who may be pregnant or may have children with them while receiving treatment in one of the adult substance abuse residential treatment programs. A registered nurse at a primary residential Alcohol and Drug treatment facility has been trained and educated by DMH staff to discuss the dangers of drinking while pregnant with the women who are receiving services.

The Annual Mississippi School for Addiction Professionals and the Annual Lookin' to the Future Conference provides sessions on youth with co-occurring disorders.

The DMH continues to provide funding to 2 community-based residential treatment programs, which make available chemical dependence residential treatment for adolescents, some of whom also have a serious emotional disturbance.

The Bureau of Alcohol and Drug Services and the Bureau of Community Services have an ongoing collaboration to continue to provide treatment services for adults with both mental illness and substance abuse disorders, participate in joint education and training initiatives, and conduct monitoring of programs throughout the state.

Priority Area 6	Prevention of Substance Abuse and Mental Illness
Goal:1	The inclusion of a workshop regarding issues of children/youth with SED and substance abuse problems in a statewide conference..
Strategy	The Division of Children and Youth Services staff members will continue to collaborate with the Bureau of Alcohol and Drug Services to develop a workshop focusing on youth with co-occurring disorders for the upcoming System of Care and/or the Mississippi School for Addiction Professionals.
Indicator	Inclusion of a workshop focusing on identification and/or treatment of youth with co-occurring disorders of serious emotional disturbance and substance abuse in a statewide conference
Baseline Measurement	In FY 2014, Kelly Wilson, LCSW, provided 1 of 2 closing general sessions at the 7th Annual Mississippi School for Addiction Professionals held in Hattiesburg, Mississippi, April 1-4, 2014. Ms. Wilson's session entitled "Trauma-Focused Cognitive Behavioral Therapy" examined the impact of trauma experienced as a child or youth and the role of maladaptive coping strategies as life preserving mechanisms for dealing with dysregulation secondary to traumatic experiences. Another session specifically addressing children and youth with co-occurring disorders of SED and substance abuse was presented by Jennifer Sigrest, LCSW, entitled "How to work with the

	LGBT Community in Treatment.”
First Year Target/Outcome Measurement	In FY 2016, the DMH Division of Children and Youth Services will include a workshop regarding issues of children/youth with SED and substance abuse/misuse problems in a statewide conference.
Second Year Target/Outcome Measurement	In FY 2017, the DMH Division of Children and Youth Services will include a workshop regarding issues of children/youth with SED and substance abuse/misuse problems in a statewide conference.
Description of Data	Conference program(s)
Criteria	Comprehensive Community-Based Mental Health Systems

Priority 6	Prevention of Substance Abuse and Mental Illness
Goal:2	To support and collaborate with community-based residential treatment services for adolescents with substance abuse problems and co-occurring disorders
Strategy	The Division of Children and Youth services will support and collaborate with community-based residential treatment program services and beds for adolescents with substance abuse problems and co-occurring disorders. Services provided include individual counseling, psychotherapeutic group counseling, self-help groups, family counseling, education services dealing with substance abuse and addiction, educational programs at the appropriate academic levels, vocational counseling services, and recreational and social activities. Additionally, DMH was awarded a 4-year grant (9/1/2013 - 8/31/2017) through SAMHSA, the Mississippi State Adolescent treatment Enhancement and Dissemination (SYT-ED) grant, to serve adolescents 12–18 years of age with co-occurring substance use and mental health disorders. This project will implement changes to policies and procedures to bolster service provision, develop financing structures, and develop an assessment and treatment blueprint for the state in partnership with 2 local community provider sites utilizing evidence-based substance abuse programming
Indicator	Number of youth served in community-based residential treatment programs for adolescents with substance abuse problems that receive funds from the DMH**;** number/type of collaborative activities/projects with community-based treatment programs
Baseline Measurement	In FY 2014, 2 programs served 111 adolescents with substance abuse problems or dual diagnosis of substance abuse and SED in community- based residential treatment. Sunflower Landing operated by CMHC Region 1 served 88 youth –(49 of whom had co-occurring disorders) and the Transitional Living Center operated by Mississippi Children’s Homes served 23 youth (14 of whom had co-occurring disorders).
First Year Target/Outcome Measurement	In FY 2016, the DMH will continue to support and collaborate with community-based residential treatment services for adolescents with substance misuse/abuse problems and co-occurring disorders.
Second Year Target/Outcome	In FY 2017, the DMH will continue to support and collaborate with community-based residential treatment services for adolescents with

Measurement	substance misuse/abuse problems and co-occurring disorders.
Description of Data	Division of Children/Youth Services Monthly Activity Form and Annual State Plan Survey
Criteria	Comprehensive Community-Based Mental Health Systems

Priority Area 6	Prevention of Substance Abuse and Mental Illness
Goal:3	To further develop the linkage between the Bureau of Alcohol and Drug Services and the Bureau of Community Services regarding COD's in individuals with SED, FASD, SMI, and Substance Abuse
Strategy	Both Bureaus will collaborate in a state-wide conference planned for FY 2016 and FY 2017 **(**MS School for Addiction Professionals), and both Bureaus will continue to monitor and provide technical assistance to co-occurring programs upon request.
Indicator	Number of technical assistance and certification visits by the DMH staff to programs implementing and/or planning programs to serve individuals with co-occurring disorders will be tracked; conference planning minutes and conference agenda; and Division of Children and Youth Monthly Reporting Form to track technical assistance provided
Baseline Measurement	In FY 2014, the DMH will continue to provide technical assistance visits as requested to programs implementing services for individuals with co-occurring disorders. Collaboration between the two Bureaus to provide a statewide conference on co-occurring disorders will also continue.
First Year Target/Outcome Measurement	In FY 2016, the DMH will continue to provide technical assistance visits as requested to programs implementing services for individuals with co-occurring disorders. Collaboration between the two Bureaus to provide a statewide conference on co-occurring disorders will also continue.
Second Year Target/Outcome Measurement	In FY 2017, the DMH will continue to provide technical assistance visits as requested to programs implementing services for individuals with co-occurring disorders. Collaboration between the two Bureaus to provide a statewide conference on co-occurring disorders will also continue.
Description of Data	Conference program, sign-in sheets, agendas, and program monitoring schedules
Criteria	Comprehensive Community-Based Mental Health Systems

Priority Area 6	Prevention of Substance Abuse and Mental Illness
Goal:4	To continue to provide community services to individuals with co-occurring disorders in all 14 mental health regions and by the community services division of 1 psychiatric hospital
Strategy	The DMH will continue to provide community services to individuals with co-occurring disorders in all 14 mental health regions and by the community services division of 1 psychiatric hospital.
Indicator	All 14 CMHCs and the Community Services Division of Mississippi State Hospital will provide services to individuals with co-occurring disorders.

Baseline Measurement	In FY 2014, 11,129 individuals in the 14 CMHCs and the Community Services Division of MSH received services for COD.
First Year Target/Outcome Measurement	In FY 2016, a minimum of 10,500 individuals will receive services for COD.
Second Year Target/Outcome Measurement	In FY 2017, a minimum of 10,500 individuals will receive services for COD.
Description of Data	Data is collected utilizing the annual state plan surveys submitted from the 15 CMHCs and MSH.
Criteria	Mental Health System Data and Epidemiology

Priority 7: Health Care and Health Systems Integration

The DMH envisions a better tomorrow where the lives of Mississippians are enriched through a public mental health system that promotes excellence in the provision of services and supports. The DMH is committed to maintaining a statewide comprehensive system of prevention, treatment and rehabilitation which promotes quality care, cost effective services, and ensures the health and welfare of individuals.

The FY 2014-2015 State Plans for Community Mental Health and Alcohol and Drug Abuse reflect the elements in the Department of Mental Health's 10-Year Strategic Plan which encompasses Integration of Behavioral Health and Primary Care Services, Recovery Supports, Provision of Services for Individuals with Co-Occurring Disorders, and Trauma.

Strategies designed to facilitate integration of mental illness and substance abuse are included in the Department's Plan (objectives to increase integration of primary and mental health care and to increase effectiveness of collaboration among community mental health providers, state agencies, governmental entities, and non-governmental entities). In 2011, the DMH began a multi-disciplinary, inter-agency Integration Work Group (IWG) whose goal is to assist with development of strategies to facilitate integrated, holistic care. IWG Membership includes individuals with expertise in adult mental health services, children's mental health services, health care/chronic disease, alcohol and drug treatment, intellectual and developmental disabilities, Alzheimer's and other dementia. IWG Membership includes representatives from Community Mental Health Centers, Community Health Centers (FQHCs), the MS State Department of Health, the MS Department of Mental Health, the MS Association of Community Mental Health Centers, etc. Collaborative efforts have included assessing in more detail the status of integration of primary and behavioral health care at local levels and consideration of model integration approaches that would be most effective in different parts of the state, given factors such as geography (rural versus urban areas), workforce availability and expertise, and the needs of the population for primary and specialty care**.** Collaborative efforts have also included educational presentations at numerous conferences including the State Department of Health, the Department of Mental Health, the Community Mental Health Center professional organization, and the MS Primary Healthcare Association. Ongoing efforts to collaborate with the MS Primary Healthcare Association and the Division of Medicaid will continue.

Examples of current collaborative activities involving mental health and/or substance abuse, primary health, and other support service providers include:

- A representative from the Department of Health and the Division of Medicaid are among child and family service agencies participating on the Interagency System of Care Council, the Interagency Coordinating Council for Children and Youth and the State-Level Case Review Team. Local representatives from the Mississippi State Department of Health are also required to participate on local, interagency Making A Plan (MAP) Teams across the state**.**
- As part of their application to the DMH for CMHS Block Grant funding, community mental health centers are required to describe how health services (including medical, dental and other supports) will be addressed for adults with serious mental illness. The CMHCs maintain a list of resources to provide medical/dental services.
- The DMH Division of Consumer and Family Affairs is facilitating incorporation of practices and procedures that promote a philosophy of recovery/resiliency across bureaus and in the DMH Operational Standards for Mental Health, Intellectual/Developmental Disabilities, and Substance Abuse Community Providers.

- The DMH Division of Alzheimer's Disease and Other Dementia partners with host agencies such as hospitals, long term care providers, and private entities to provide education and training events.
- The DMH Bureau of Alcohol and Drug Services continues to work with the Attorney General's Office in enforcement of the state status prohibiting the sale of tobacco products to minors and to ensure that the state compliance check survey is completed in a scientifically sound manner.
- The DMH Bureau of Alcohol and Drug Services partners with the MS Department of Rehabilitation Services to fund substance abuse treatment services to individuals in transitional residential programs.
- The DMH Bureau of Alcohol and Drug Services work collaboratively with the MS Band of Choctaw Indians and continue to fund prevention services with Choctaw Behavioral Health.
- The DMH Bureau of Alcohol and Drug Abuse has a partnership with the Office of Tobacco Control to improve tobacco cessation services in the state. The DMH BADA partnership includes trainings around the state. The training is also available for A&D personnel located at community mental health centers.
- The DMH Bureau of Community Services' Annual Provider Survey gathers self-reported information on integrated primary and behavioral health care, as well as on tele-medicine opportunities.
- In December 2014, the DMH Bureau of Community Services and the DMH Bureau of Outreach, Planning and Development applied for and were awarded membership in the SAMHSA-HRSA Center for Integrated Health Solution's (CIHS) Innovation Community entitled Building Integrated Behavioral Health in a Primary Care Setting. This collaboration is between the DMH, a local CMHC, and a local FQHC.
- In March 2015, the DMH Division of Recovery and Resiliency applied for and was awarded a 2015 Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) Subcontract for the Expansion of Policy Academy Action Plans.

Priority Area 7	Health Care and Health Systems Integration
Goal:1	FASD screening assessments will be made available in all 14 CMHC regions across the state, and other DMH certified providers, to determine the need for a diagnostic evaluation in children/youth birth–18 years of age.
Strategy	The DMH Operational Standards require children birth–18 years of age to be screened within 6 months of Intake to determine the need for a FASD diagnostic evaluation for identification of primary health and behavioral health problems, and for intervention and treatment by behavioral and primary care providers in the local community.
Indicator	Number of positive FASD screenings will be reported.
Baseline Measurement	In FY 2014, 5,076 children and youth, birth–18 years of age, were screened for a FASD at CMHCs in Mississippi. 281 children and youth screened positive for a FASD in FY 2014.
First Year Target/Outcome Measurement	In FY 2016, FASD screening assessments will be made available in all 14 CMHC regions across the state. Number of positive FASD screenings will be reported.
Second Year Target/Outcome Measurement	In FY 2017, FASD screening assessments will be made available in all 14 CMHC regions across the state. Number of positive FASD screenings will be reported.

Description of Data	The number of FASD screenings conducted each year in or through the CMHCs and other DMH certified providers are submitted from providers utilizing the DMH Division of Children and Youth Monthly Service Report forms and entered into a database by staff in the DMH Division of Children and Youth Services.
Criteria	Comprehensive Community-Based Mental Health Systems for Children and Youth with SED

Priority Area 7	Health Care and Health Systems Integration
Goal:2	To increase access to community-based, co-integrated, holistic care and supports through a network of service providers committed to a resiliency and recovery-oriented system of care
Strategy	The DMH Bureaus and Divisions will promote interagency and multidisciplinary collaboration and partnerships by participating in meetings and actions of the Integration Work Group (IWG). Through the IWG, the DMH will develop strategies and increase partnerships to facilitate integration of mental illness, intellectual and developmental disabilities, and addiction services with primary health care to encompass a holistic care approach to service provision. The IWG developed an informal baseline document from which to measure growth in knowledge of and in provision of co-integrated services. Annually, additional information on primary and behavioral health care integration will be gathered by survey by the DMH Bureau of Community Services. The DMH will also continue to seek and develop possible funding opportunities for integrated care.
Indicator	Attendance records at IWG meetings, updated information in Annual Community Services Survey concerning integrated primary and behavioral health care services, documentation of collaboration on grant application, multidisciplinary collaboration and participation, baseline information from community-based programs concerning integrated primary and behavioral healthcare, and documentation of collaborative meetings on grant opportunities
Baseline Measurement	In FY 2014, the IWG met 4 times. The Annual Community Services Survey was conducted in late 2013. Based upon a review of the self-reported data, it is estimated that, as of June 30, 2013, approximately 6 of 23 programs have shown progress toward the development of integrated care.
First Year Target/Outcome Measurement	In FY 2016, the IWG will meet a minimum of 4 times showing interagency and multidisciplinary collaboration participation. The Annual Community Services Survey will be conducted in late 2015. Grant application(s) will be submitted if opportunities are available.
Second Year Target/Outcome Measurement	In FY 2017, the IWG will meet a minimum of 4 times showing interagency and multidisciplinary collaboration participation. The Annual Community Services Survey will be conducted. Grant application(s) will be submitted if opportunities are available.
Description of Data	Attendance records and documentation, FY 2012 baseline data, Annual Community Services Surveys are conducted at the end of each calendar year to collect information from the previous fiscal year. This updated information will be added to the baseline document each year and will be used by the IWG to assist in

	developing strategies for the next year. Documentation of grant activities is maintained, including meeting notes and grant applications.
Criteria	Comprehensive Community-Based Mental Health Systems

Priority 8: Trauma and Justice

Most individuals seeking public health services and many other public services, such as homeless and domestic violence services, have histories of physical and sexual abuse, and other types of trauma-inducing experiences. These experiences often lead to mental health and co-occurring disorders, HIV/AIDS, as well as contact with the criminal justice system. When programs take the step to become trauma-informed, every part of their organization, management, and service delivery system should be assessed and have a basic understanding of how trauma affects the lives of these individuals seeking services, the vulnerabilities, and/or triggers of trauma survivors.

The Mississippi Department of Mental Health, Bureau of Community Services and the Bureau of Alcohol and Drug Services are working collaboratively to provide training intended to address the effects of trauma. These trainings will be particularly helpful for adult and child survivors of abuse, disaster, crime, shelter populations, and others. It will be aimed at promoting relationships rather than focusing on the traumatic events in their lives. The trainings can also be utilized by first providers, frontline service providers and agency staff.

Providers of children and youth mental health services in Mississippi are being trained in trauma-specific interventions such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS). The Department of Mental Health, Division of Children and Youth Services is providing trauma-informed trainings to community and state partners including family members and caregivers. Mississippi has two National Child Traumatic Stress Network Sites, Catholic Charities, Inc. and Region 13/Gulf Coast Mental Health Center.

Priority Area 8	Trauma and Justice
Goal:1	To educate and train community leaders on Mental Health First Aid
Strategy	The DMH staff will train pastors, teachers, civic groups, and families and friends on Mental Health First Aid.
Indicator	Number of trainings by DMH staff, agenda, sign-in sheets
Baseline Measurement	In FY 2014, the Division of Children and Youth Staff provided 12 MHFA trainings to members of the Mobile Crisis Emergency Response Teams (MCERTs) for staff at the CMHCs, teachers and school personnel, mental health service providers, and staff from the Department of Rehabilitation Services.
First Year Target/Outcome Measurement	In FY 2016, the DMH will educate and train community leaders on Mental Health First Aid.
Second Year Target/Outcome Measurement	In FY 2017, the DMH will educate and train community leaders on Mental Health First Aid.
Description of Data	Number of trainings, sign-in sheets, agendas
Criteria	Comprehensive Community-Based Mental Health Systems

Priority Area 8	Trauma and Justice
Goal:2	To provide an array of trainings on trauma throughout the state

Strategy	The Bureau of Alcohol and Drug Services will provide trauma sessions at the Annual Mississippi School for Addiction Professionals. They will focus on Trauma Informed Care, Trauma Focused Cognitive Behavioral Therapy (TFCBT), and Recovery. The Division of Children and Youth Services staff will provide trauma-informed trainings upon request and sponsor a Statewide Trauma-Informed Care Conference.
Indicator	Number of trainings by DMH staff, agenda, sign-in sheets
Baseline Measurement	In 2014, the Division of Children and Youth staff provided 12 trainings on Trauma-Informed Care to a diverse group of participants which included staff at Sunnybrook Children's Home, East Mississippi State Hospital, the Jackson Public School District (Capital City Alternative School), and the Department of Human Services (social workers). Breakout sessions on Trauma-Informed Care were included on the agendas at the at the following conferences: Violence, Trauma, and Healing, Lookin' to the Future, APSE, MH/IDD Joint Conference, Juvenile Justice Symposium, and the Child Welfare Symposium.
First Year Target/Outcome Measurement	In 2016, the DMH will provide an array of trainings on trauma throughout the state.
Second Year Target/Outcome Measurement	In 2017, the DMH will provide an array of trainings on trauma throughout the state.
Description of Data	Number of trainings, sign-in sheets, agendas
Criteria	Comprehensive Community-Based Mental Health Systems

Priority 9: Comprehensive Community-Based Mental Health Systems for Adults with SMI

An adult with SMI refers to persons ages 18 and older; (1) who currently meets or at any time during the past year has met criteria for a mental disorder – including within developmental and cultural contexts – as specified within a recognized diagnostic classification system (e.g., most recent editions of DSM, ICD, etc.), and (2) who displays functional impairment, as determined by a standardized measure, which impedes progress towards recovery and substantially interferes with or limits the person's role or functioning in family, school, employment, relationships, or community activities.

Regional community mental health centers (CMHCs) operate under the supervision of regional commissions appointed by county boards of supervisors comprising their respective service areas. The 14 CMHCs make available a range of community-based mental health, substance abuse, and in some regions, intellectual/developmental disabilities services. CMHC governing authorities are considered regional and not state-level entities. The DMH is responsible for certifying, monitoring, and assisting CMHCs. CMHCs are the primary service providers with whom the DMH contracts to provide community-based mental health and substance abuse services.

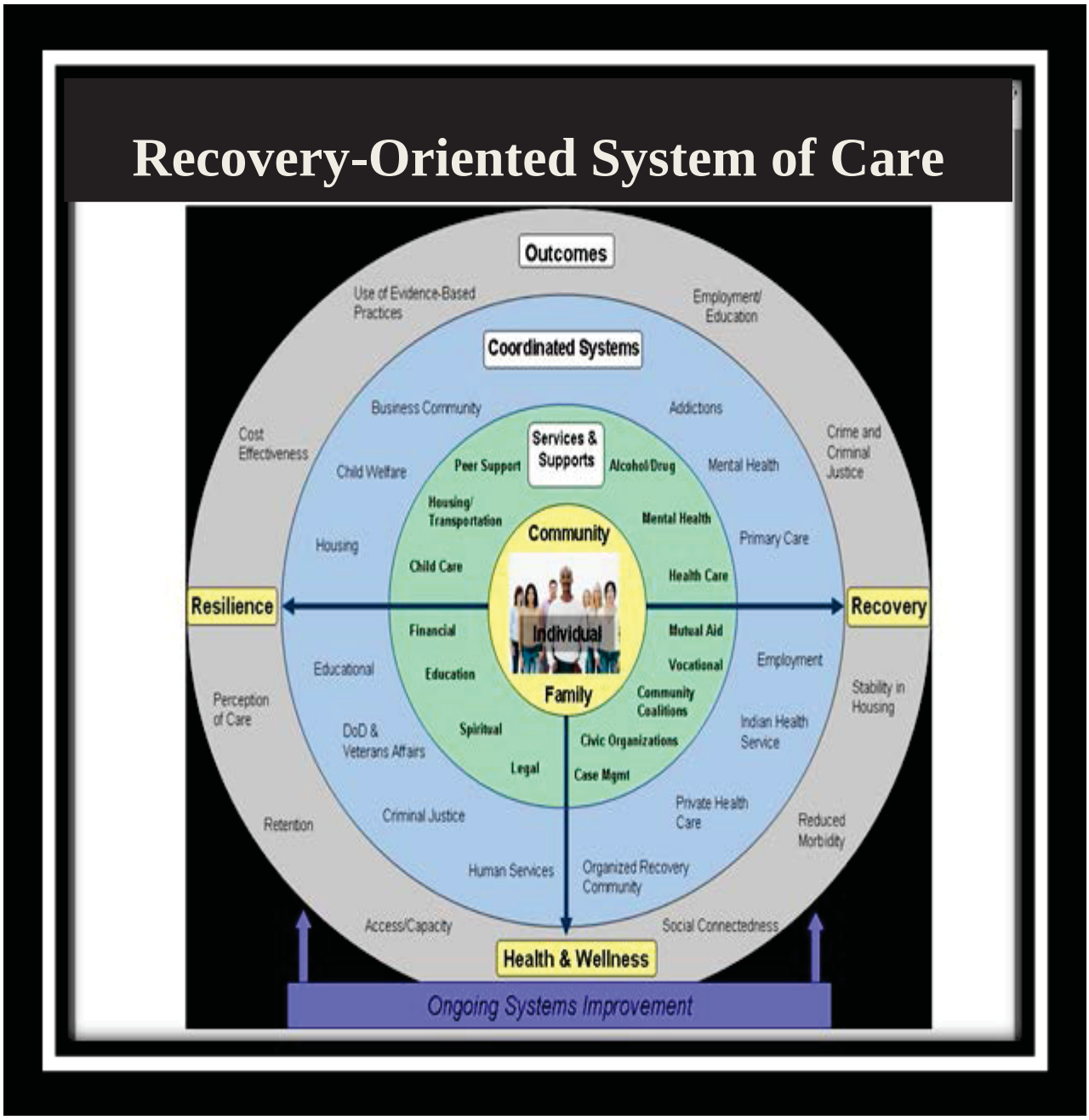
The DMH coordinates and establishes minimum standards and minimum required services for regional mental health and intellectual disability commissions and other community service providers for community or regional programs and services in mental health, intellectual disability, alcoholism, drug misuse, developmental disabilities, compulsive gambling, addictive disorders, and related programs throughout the state.

Implementation of these standards, is monitored through on-site visits of programs throughout the year by the DMH staff. Community services are also provided to individuals through the Community Services Divisions of the two larger state psychiatric hospitals. These programs are also monitored for compliance of the Operational Standards applicable to the community mental health programs they provide.

Recovery-Oriented System of Care

The Recovery-Oriented System of Care model is designed to support individuals seeking to overcome mental health disorders and substance use disorders across their lifespan. There is no wrong door to recognize the recovery-oriented system of care needs to provide "genuine, free and independent choice" among an array of treatment and recovery support options. Services should optimally be provided in flexible, unbundled packages that evolve over time to meet the changing needs of recovering individuals. Individuals should also be able to access a comprehensive array of services that are fully coordinated to provide support to individuals. At the center of the system is the individual, community, and family. Several types of service options and activities may be included in the service components. A major change in the description of characteristics of the system has been made to reflect a philosophy shift to one that is more individualized. Strategies to evaluate and improve the effectiveness of local advisory councils, comprised of consumers and family members, have been included in system improvement efforts. The service components of the Recovery-Oriented System of Care model include: consumer support services**,** outpatient services, crisis response services, community living options**,** identification and outreach, psychosocial rehabilitation services, supported employment, family/consumer education and

support, inpatient services, protection and advocacy, and other support services. Services for individuals with a co-occurring disorder of serious mental illness and substance abuse are also included in the system of community-based care.



Priority Area 9	Comprehensive Community-Based Mental Health Systems for Adults with SMI
Goal:1	To continue developing a program evaluation system which promotes accountability and improves quality of care in community mental health services
Strategy	The DMH will continue to refine the quality assurance process for all adult community mental health programs and services by incorporating the voice of individuals and/or family members in the planning, evaluation, and implementation of services.
Indicator	Improved access and outcomes of services to individuals receiving services will be reported. Number of consumers and family members involved in decision-making activities including: advisory councils, task forces, and work groups on a state level will be increased. The involvement of individuals and/or family members in evaluating services through POM interviews will be increased.
Baseline Measurement	In FY 2014, there were approximately 35 individuals and/or family members participating in advisory councils, task forces, and work groups at the state level. There were 35 individuals trained to conduct POM interviews. 170 POM interviews were conducted. There were 97 individuals and/or family members trained as Certified Peer Support Specialists.
First Year Target/Outcome Measurement	In 2016, the number of individuals and/or family members participating in advisory councils, task forces, and work groups will be increased
Second Year Target/Outcome Measurement	In 2017, the number of individuals and/or family members participating in advisory councils, task forces, and work groups will be increased.
Description of Data	Work group reports, sign-in sheets, minutes from meetings
Criteria	Comprehensive Community-Based Mental Health Systems

Priority Area 9	Comprehensive Community-Based Mental Health Systems for Adults with SMI
Goal:2	To make available community based, statewide, comprehensive system of services and supports for adults with mental illness to support an array of "Core" services to assist adults with serious mental illness.
Strategy	The DMH will continue to provide grants, support and technical assistance to community providers that offer an array of community mental health services and supports. These services include: Outpatient Services, a component of the ideal system, includes diagnostic and treatment services in various treatment modalities for persons requiring less intensive care than inpatient services, including individuals with serious mental illness Psychosocial Rehabilitative Services consist of a network of services designed to support and restore community functioning and well-

	being of adults with a serious and persistent mental illness. The purpose of the program is to promote recovery, resiliency, and empowerment of the individual in his/her community. Day Support Services provide structured, varied and age appropriate clinical activities in a group setting that are designed to support and enhance the individual's independence in the community through the provision of structured supports. Acute Partial Hospitalization is a psychosocial rehabilitative service that is designed to provide an alternative to inpatient hospitalization or to serve as a bridge from inpatient to outpatient treatment. Supported Living includes an array of supports and services that are provided in an integrated community setting by a provider with appropriate staff and resources to assist an individual who needs assistance less than 24 hours per day/7 days per week. Supervised Living includes an array of supports and services provided with appropriate staff and resources to support an individual who needs assistance 24 hours per day/7 days per week to live in the community. Community Support Services provide an array of support services delivered by community-based, mobile Community Support Specialists. Psychiatric/Physician's Services are services of a medical nature provided by medically trained staff to address medical conditions related to the individual's mental illness or emotional disturbance. Crisis Stabilization Services are time-limited residential treatment services provided in a Crisis Stabilization Unit which provides psychiatric supervision, nursing services, structured therapeutic activities and intensive psychotherapy to individuals who are experiencing a period of acute psychiatric distress. Peer Support Services are person-centered activities with a rehabilitation and resiliency/recovery focus that allow consumers of mental health services and their family members the opportunity to build skills for coping with and managing psychiatric symptoms and challenges associated with various disabilities while directing their own recovery. Targeted Case Management Services provide information and resource coordination for individuals and collaterals. These services are directed toward helping individuals maintain the highest possible level of independent functioning.

	Supported Employment Services will be provided in 4 pilot program sites (Regions 2, 7, 10, and 12) to begin implementation of supported employment services for adults living with Mental Illness in Mississippi to increase employment opportunities for adults living with Mental Illnesses.
Indicator	The number of individuals served in the community will be tracked.
Baseline Measurement	In FY 2014, 70,334 individuals were served in the community.
First Year Target/Outcome Measurement	In 2016, a minimum of 74,000 individuals will be served in the community.
Second Year Target/Outcome Measurement	In 2017, a minimum of 74,000 individuals will be served in the community.
Description of Data	Documentation of grant award on file at the DMH; monthly cash requests, satisfaction surveys
Criteria	Mental Health System Data and Epidemiology

Priority Area 9	Comprehensive Community-Based Mental Health Systems for Adults with SMI
Goal:3	To provide supports to the CSU to allow adults with SMI to remain in the community and reduce hospitalizations
Strategy	The DMH will continue to provide funding to the Crisis Stabilization Units throughout the state.
Indicator	Decrease in the number of admissions to behavioral health programs.
Baseline Measurement	In FY 2014, 4,007 individuals were diverted from the behavioral health programs and admitted to the CSUs.
First Year Target/Outcome Measurement	In 2016, 4,000 individuals will be diverted to the CSUs.
Second Year Target/Outcome Measurement	In 2017, 4,000 individuals will be diverted to the CSUs
Description of Data	Documentation of grant awards on file at the DMH; monthly cash requests, CSUs submit daily census reports monthly, CSUs submit monthly data report
Criteria	Comprehensive Community-Based Mental Health Systems for Adults with SMI

Priority Area 9	Comprehensive Community-Based Mental Health Systems for Adults with SMI
Goal:4	To increase employment opportunities for Adults living with Mental Illnesses through IPS Supported Employment Services
Strategy	1. The DMH will utilize legislative appropriated community expansion general funds to provide 4 pilot program sites (Regions 2, 7, 10, and 12) to begin implementation of supported employment

	services for adults living with Mental Illness in Mississippi. The DMH will retain the consultative services of a nationally recognized expert in the development and implementation of sustainable IPS Supported Employment Programs for Adult Mississippians living with Mental Illnesses. The DMH will pursue the attainment of a State Plan Amendment (SPA) or 1915-I waiver through the Division of Medicaid as a source of sustainable funding to further develop the availability of the service. 2. The DMH will collaborate with Vocational Rehabilitation Services to interdependently leverage each agency's ability to provide employment supports for persons living with mental Illness.
Indicator	Increase in the number of clients who are gainfully employed
Baseline Measurement	New Goal. No Baseline Data Available
First Year Target/Outcome Measurement	In FY 2016, to have all 4 programs fully staffed and trained with supported employment specialist and to have a cumulative minimum of 50 clients gainfully employed in competitive jobs
Second Year Target/Outcome Measurement	In FY 2017, to have a cumulative minimum of 100 clients gainfully employed in competitive jobs
Description of Data	Monthly Report
Criteria	Comprehensive Community-Based Mental Health Systems for Adults with SMI

Priority Area 9	Comprehensive Community-Based Mental Health Systems for Adults with SMI
Goal:5	To address the stigma associated with mental illness through a mental illness campaign
Strategy	The DMH will continue to lead a statewide public education effort to counter stigma and bring down barriers that keep people from seeking treatment by leading statewide efforts in the anti-stigma campaign.
Indicator	Estimated number of individuals reached through educational/media campaign, based on tracking the number of printed materials including press releases, newspaper clippings, brochures, and flyers – 200,000 The DMH will also track the number of live interviews and presentations.
Baseline Measurement	In FY 2014, 50 presentations were conducted. More than 120,000 brochures have been distributed since 2008 and more than 10,000 potty posters have been distributed to schools across the state. Mississippi teachers are now required to participate in suicide prevention treatment.
First Year Target/Outcome Measurement	In 2016, the DMH will continue to address the stigma associated with mental illness through a mental illness awareness campaign through the development of a media guidebook to educate the media and journalism students about mental health.
Second Year	In 2017, the DMH will continue to address the stigma associated with

Target/Outcome Measurement	mental illness through a mental illness awareness campaign through continued awareness activities and the media guidebook project.
Description of Data	Media and educational presentation tracking data maintained by the DMH Director of Public Information
Criteria	Comprehensive Community-Based Mental Health Systems for Adults with SMI

Priority 9	Comprehensive Community-Based Mental Health Systems for Adults with SMI
Goal :6	Increase the number of Adult Day Programs for individuals with SMI
Strategy	Staff will research best practices for respite services; review models funded through alternative sources such as federal funding sources and foundational funding sources, and review other states' models for respite services. Progress will be reported to the Alzheimer's Planning Council.
Indicator	The number of adult day programs certified by the DMH
Baseline Measurement	In FY 2014, the DMH certified 2 Alzheimer adult day programs.
First Year Target/Outcome Measurement	In 2016, the DMH will certify 4 Alzheimer adult day programs.
Second Year Target/Outcome Measurement	In 2017, the DMH will certify 4 Alzheimer adult day programs.
Description of Data	Number of program certificates, summary of respite services review activities
Criteria	Comprehensive Community-Based Mental Health Systems

Priority Area 9	Comprehensive Community-Based Mental Health Systems for Adults with SMI
Goal:7	Coordinate oversight and implementation of components of the State Strategic Plan for Alzheimer's Disease and Related Dementia 2015 – 2020
Strategy	Staff will coordinate meetings with Goal Leaders of the State Strategic Plan for Alzheimer's Disease and Related Dementia 2015 – 2020. Staff Will strengthen collaborations with stakeholders and contributors to the Implementation Plan. Staff will report State Plan progress quarterly to the Alzheimer's Planning Council.
Indicator	Implementation Plan, activity tracking reports, Alzheimer's Planning Council minutes.
Baseline Measurement	No Goal. No baseline data available.

First Year Target/Outcome Measurement	In 2016, implementation strategies will be identified for 50% of objectives in each goal section.
Second Year Target/Outcome Measurement	In 2017, implementation strategies will be identified for 75% of objectives in each goal section
Description of Data	Number of implementation strategies per goal section, summary of plan activities
Criteria	Comprehensive Community-Based Mental Health Systems

Priority 9	Comprehensive Community-Based Mental Health Systems for Adults with SMI
Goal: 8	Implement Law Enforcement Training Course entitled, "Older Adults, Dementia, Elder Abuse and Silver Alert" in Law Enforcement Training Academies statewide as part of the mandatory Basic Training Curriculum for all Law Enforcement Training Cadets.
Strategy	Staff will coordinate scheduling of the course with Law Enforcement Training Academy program coordinators to encourage regular inclusion of the course in each training academy schedule.
Indicator	Number of courses taught; number of Academies receiving training; number of cadets receiving training.
Baseline Measurement	No Goal. No baseline data available.
First Year Target/Outcome Measurement	In 2016, the course entitled, “Older Adults, Dementia, Elder Abuse and Silver Alert”, will be taught in 75% of Law Enforcement Training Academies.
Second Year Target/Outcome Measurement	In 2017, the course entitled, “Older Adults, Dementia, Elder Abuse and Silver Alert,” will be taught in 100% of Law Enforcement Training Academies.
Description of Data	Learner Satisfaction Surveys, Pre-test and Post-test
Criteria	Comprehensive Community-Based Mental Health Systems

Priority Area 9	Comprehensive Community-Based Mental Health Systems for Adults with SMI
Goal: 9	To improve cultural relevance of mental health services through identification of issues by the Multicultural Task Force
Strategy	Meetings/activities by the Multicultural Task Force will be conducted. The ongoing functioning of the Multicultural Task Force has been incorporated in the State Plan to identify and address any issues relevant to persons in minority groups in providing quality community mental health services and to improve the cultural awareness and sensitivity of staff working in the mental health system. The Day of

	Diversity coordinated by the Multicultural Task Force includes participation by local agencies, family members, and community members in the CMHCs' regional areas. The Multicultural Task Force will develop a disparity statement that will address equity in mental health services and supports.
Indicator	The number of meetings of the Multicultural Task Force (at least 2 per year) with a report to the Mississippi State Mental Health Planning and Advisory Council when requested or as needed.
Baseline Measurement	In FY 2014, the Multicultural Task Force met on October 18, 2013, on February 11, 2014, and on May 2, 2014. The task force organized the Day of Diversity which was held on October 13, 2014. The task force members also participated in the National Minority Mental Health Awareness events throughout the state in the month of July. A report to the Mississippi Mental Health Planning and Advisory Council regarding the activities of the task force occurred on November 13, 2014.
First Year Target/Outcome Measurement	In FY 2016, the Multicultural Task Force will have at least 2 meetings.
Second Year Target/Outcome Measurement	In FY 2017, the Multicultural Task Force will have at least 2 meetings.
Description of Data	Minutes of task force meetings and minutes of Planning Council meeting(s) at which task force report(s) are made
Criteria	Comprehensive Community-Based Mental Health Systems

State Priority 10: Targeted Services to Rural and Homeless Adults with SMI

The DMH continues to support specialized services targeting individuals who are homeless and have mental illness in areas of the state where there are known to be large homeless populations with a significant number of individuals with mental illness and where the Projects for Assistance in Transition from Homelessness (PATH) funds would have the greatest impact (Jackson, Meridian, and the Gulf Coast).

The DMH staff continues to participate with Partners to End Homelessness CoC to help plan for and coordinate services for individuals with mental illness who may be experiencing homelessness. When feasible, DMH staff also attend the MS United to End Homelessness (MUTEH) CoC meetings as well as the Open Doors CoC meetings.

The DMH continues to receive technical assistance in the implementation of the SSI/SSDI Outreach, Access, and Recovery (SOAR) Program in Mississippi as provided by SAMHSA. The purpose of SOAR is to help states increase access to mainstream benefits for individuals who are homeless or at risk for homelessness through specialized training, technical assistance, and strategic planning for staff that provide services to these individuals. Mississippi is also participating in SOAR data collection as part of the national SOAR evaluation process. While 6 DMH or service provider staff have completed the SOAR Train the Trainer process and have in turn trained a number of service providers in the SOAR method in the past, the SOAR training is now available online. The DMH provides information and oversight regarding the online training. There is an online SOAR data collection system that SOAR processors in the state are encouraged to use to report the results of the SSI/SSDI applications that are submitted using SOAR.

Community mental health centers will continue to be required to develop plans for outreach, including transportation, as part of their community support services plans approved by the DMH. While transportation to services continues to be a challenge in the rural areas of the state, the community mental health centers find themselves needing to offer some type of transportation for individuals in need of services who do not have options available. In most cases, the community mental health centers have vans and/or small buses that can be used to transport individuals. They also partner with the providers in their service region that receive grants from the Mississippi Department of Transportation to provide transportation for needed services in rural areas. They also partner with the local Title XX or other state or federally-funded rural transportation providers to address this potential barrier to services in the most effective way possible.

Priority Area 10	Targeted Services to Rural and Homeless Adults with SMI
Goal:1	To provide coordinated supportive services for individuals with mental illness who are homeless or chronically homeless
Strategy	The DMH will continue to provide targeted services for individuals with mental illness in the state who are homeless or chronically homeless.
Indicator	The number of persons with serious mental illness served through specialized programs for individuals with mental illness who are homeless or chronically homeless
Baseline Measurement	In FY 2014, 1,288 persons with serious mental illness were served through specialized programs for homeless persons.

First Year Target/Outcome Measurement	In 2016, a minimum of 950 persons with serious mental illness will be served through specialized programs for homeless persons.
Second Year Target/Outcome Measurement	In 2017, a minimum of 950 persons with serious mental illness will be served through specialized programs for homeless persons.
Description of Data	Adult Services State Plan Survey; PATH Grant Annual Report
Criteria	Targeted Services to Rural and Homeless Populations

Priority Area 10	Targeted Services to Rural and Homeless Adults with SMI
Goal:2	To educate providers, consumers, and other interested individuals/groups about the needs of homeless individuals, including the needs of individuals with mental illness who are homeless or chronically homeless
Strategy	A DMH staff member will continue to participate on interagency workgroups that identify and/or address the needs of individuals who are homeless or chronically homeless. A DMH staff member continues to participate in the 3 Continua of Care in Mississippi (i.e., Open Doors, Mississippi United to End Homelessness, Partners to End Homelessness), as well as the State Planning Council meetings. DMH staff actively participate in the Mississippi Permanent Supportive Housing Council that seeks to address the housing needs of individuals with mental illness who are homeless. A DMH staff member has presented information to these groups on the PATH Program, the State SOAR Initiative and the Cooperative Agreement to Benefit Homeless Individuals (CABHI)-States program to expand/enhance services to individuals with serious mental illness who are homeless or chronically homeless. A DMH staff person is the Team Leader for the Medicaid Balancing Incentives Program (BIP) Housing Team which is tasked with the responsibility of making recommendations to the Mississippi Division of Medicaid regarding ways to improve and expand housing options for individuals with serious mental illness and other special needs and disabilities.
Indicator	The number of committees or workgroups addressing homelessness on which DMH staff member(s) participate – up to 3
Baseline Measurement	In FY 2014, the DMH staff participated in 3 workgroups addressing homelessness.
First Year Target/Outcome Measurement	In 2016, the DMH staff will attend a minimum of 2 workgroups addressing homelessness.
Second Year Target/Outcome Measurement	In 2017, the DMH staff will attend a minimum of 2 workgroups addressing homelessness.
Description of Data	Minutes of workgroup meetings and/or Division Activity Reports
Criteria	Targeted Services to Rural and Homeless Populations

State Priority 11: Health Information Technology

Management goals that assist in improving information management systems, continuing helpline services through the Office of Consumer Support Services and requesting additional funding for community mental health services to both child and adult service address this priority.

Priority Area 11	Health Information Technology
Goal:1	Develop an Electronic Health Records system to improve services provided to individuals served
Strategy	1. Utilize computerized provider order entry (CPOE) for medication orders 2. Replace manual reporting with electronic online reporting 3. Utilize client web portal for reviewing their health information 4. Create a centralized web portal for checking bed availability at Behavioral Health Programs based on data from EHR
Indicator	1. Report to CMS for Meaningful Use 2. Number of permissible prescriptions and lab requests generated and transmitted electronically (eRx) 3. % of clients served who view their health information online 4. % of occupancy of inpatient beds
Baseline Measurement	New goal. No baseline data available.
First Year Target/Outcome Measurement	In FY 2016, the DMH will implement an Electronic Health Records system at all DMH Behavioral Health Programs and IDD Programs and automate the interface from the electronic health records system to labs, pharmacies, and Dr. First.
Second Year Target/Outcome Measurement	In FY 2017, the DMH will develop a bed registry to track data daily to maximize the availability of DMH operated and funded program beds.
Description of Data	To meet the Meaningful Use requirements, the following criteria must be reported to CMS: ▪ Use CPOE (computerized physician order entry) for medication orders ▪ Implement drug-drug and drug-allergy interaction checks ▪ Maintain an up-to-date problem list of current and active diagnosis ▪ Maintain active medication list ▪ Record client demographics ▪ Record and chart changes in vital signs ▪ Record smoking for patients 13 years old or older ▪ Provide patients with the ability to view online information about hospital admission ▪ Incorporate clinical lab-test results into an electronic health records system
Criteria	Comprehensive Community-based

Priority Area 11	Health Information Technology
Goal:2	Maximize the efficiency of collecting and accessing Central Data Repository
Strategy	Establish CDR user groups for DMH Programs, CMHCs, and Private Providers who meet on a quarterly basis
Indicator	% of participants in user groups compared to total DMH number of DMH Certified Providers
Baseline Measurement	Develop a dashboard for the DMH leadership to track progress and eliminate manual reporting
First Year Target/Outcome Measurement	In FY 2016, the DMH will increase the validity and timely reporting of data by 30% to meet federal, state, and DOJ reporting requirements.
Second Year Target/Outcome Measurement	In FY 2017, the DMH will utilize a dashboard for 20% of service categories for CDR and URS tables and increase access to all CDR reports and dashboard by creating 1 central location.
Description of Data	Participants in user groups, DMH Certified Providers
Criteria	Comprehensive Community-Based Mental Health Systems

Priority Area 11	Health Information Technology
Goal:3	The Office of Consumer Support (OCS) is responsible for maintaining a toll-free line and providing assistance to individuals receiving services and their families. The OCS assists in resolving grievances related to access to services and service provision, providing education regarding the rights of individuals receiving services, and responding to general questions concerning services for individuals with serious mental illness, intellectual/development disabilities, and substance use disorders.
Strategy	The nature and frequency of calls from consumers and the general public via computerized caller information and reporting mechanisms included in the information and referral software will be tracked.
Indicator	The number and category of calls received through the helpline
Baseline Measurement	In FY 2014, the helpline received approximately 4,500 calls and responded to more than 75 grievances. The Office of Consumer Support assisted with referrals, resolving grievances, access to services, and providing information regarding services.
First Year Target/Outcome Measurement	In 2016, the DMH will continue to operate the helpline.
Second Year Target/Outcome Measurement	In 2017, the DMH will continue to operate the helpline.
Description of Data	Information collected from the DMH database
Criteria	Comprehensive Community-Based Mental Health Systems

State Priority 12: Work Force Development

Priority Area 12	Workforce Development
Goal:1	To expand skills training to services providers in the provision of services for Adults with SMI
Strategy	The DMH will continue to provide training, support, and technical assistance to staff working with adults with SMI. The Department of Mental Health Consumer Support Specialist is an internet-based staff training and development program. The Relias Learning training website tracks staff training and eliminates the need for extensive travel for case managers to obtain training.
Indicator	The number of community mental health services staff who receive training
Baseline Measurement	In FY 2014, 81 staff who work with adults with SMI were enrolled in the Relias Learning training website.
First Year Target/Outcome Measurement	In 2016, a minimum of 60 staff who work with adults with SMI will receive training through the Relias Learning training website.
Second Year Target/Outcome Measurement	In 2017, a minimum of 60 staff who work with adults with SMI will receive training through the Relias Learning training website.
Description of Data	The DMH Learning Management System
Criteria	Comprehensive Community-Based Mental Health Systems

Priority Area 12	Workforce Development
Goal:2	Utilize evidence-based or best practices among DMH Certified Providers for core services
Strategy	Promote at least 6 evidence-based and promising practices trainings offered through the DMH learning management system through internal communication efforts
Indicator	Increase the number of evidence-based and emerging best practices trainings each year
Baseline Measurement	New Goal. No baseline data available.
First Year Target/Outcome Measurement	In FY 2016, the DMH will continue to promote at least 6 evidence-based and promising practices trainings offered through the DMH learning management system through internal communication efforts.
Second Year Target/Outcome Measurement	In FY 2017, the DMH will continue to promote at least 6 evidence-based and promising practices trainings offered through the DMH learning management system through internal communication efforts.
Description of Data	DMH Learning System, Evidence-based trainings
Criteria	Comprehensive Community-Based Mental Health Systems

SECTION III
PLANNED EXPENDITURES

Planning Tables

Table 2 State Agency Planned Expenditures

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Activity	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment							
a. Pregnant Women and Women with Dependent Children*							
b. All Other							
2. Substance Abuse Primary Prevention							
3. Tuberculosis Services							
4. HIV Early Intervention Services							
5. State Hospital			$0	$0	$0	$0	$0
6. Other 24 Hour Care		$0	$0	$0	$0	$0	$0
7. Ambulatory/Community Non-24 Hour Care		$4,235,346	$0	$20,004,907	$26,655,115	$0	$3,350
8. Mental Health Primary Prevention**		$0	$0	$0	$0	$0	$0
9. Evidenced Based Practices for Early Intervention (5% of the state's total MHBG award)		$211,767	$0	$0	$0	$0	$0
10. Administration (Excluding Program and Provider Level)		$211,767	$0	$0	$0	$0	$0
13. Total	**$0**	**$4,658,880**	**$0**	**$20,004,907**	**$26,655,115**	**$0**	**$3,350**

* Prevention other than primary prevention

** It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Footnotes:

SECTION IV
NARRATIVE PLAN

1. Health Care System and Integration

Beginning in 2009, the integration of mental illness, intellectual and developmental disabilities and addiction services with primary health care has been included in the DMH Strategic Plan. From 2010-2012, the DMH actively participated on the MS Department of Health's Patient-Centered Medical Home Advisory Committee. The Advisory Committee was charged with development of guidelines for Patient-Centered Medical Homes as per House Bill 1192 (2010 Regular Session of the MS State Legislature). Final guidelines were issued on September 25, 2012 (with an amendment dated October 31, 2012). The DMH Executive staff members participated in a State Health Summit held in August 2012 which was hosted by the Dr. Mary Currier, MS State Health Official. One area of focus was on the integration of behavioral health services. The DMH has continued to participate in the Mississippi Health Summit each year, most recently in May 2015.

In 2011, the DMH formed an Integration Work Group (IWG) to develop strategies to facilitate integration of primary and MI/IDD/AD services. Membership has continued to grow and expand each year. In 2015, current membership includes: individuals representing adult mental health services, children/youth mental health services, alcohol and substance abuse services, intellectual and developmental disability services, Alzheimer's/dementia services, community services programs, nursing, the DMH medical director, representatives from the MS Association of Community Mental Health Centers, the MS State Department of Health, community mental health center representatives and representatives of local federally qualified health centers. By June 30, 2012, the IWG had developed a Baseline Document of all known integrated services within the state mental health system. This Baseline Document is updated annually with information submitted in response to an annual Community Services Survey. Information from the Baseline Document was first shared at a statewide conference in October 2012. Since then, DMH and the IWG has embarked on a multi-agency effort to socialize integrated care concepts by making presentations at a number of statewide conferences, including the 2013 Biennial MS State Department of Health Conference, the 2014 Annual MS Association of Community Mental Health Centers Conference, the 2014 Annual MH/AIDD Conference, the 2015 Biennial MS State Department of Health Conference and the 2015 Annual Conference for the MS Primary Health Care Association. Throughout 2014-2015, DMH also included MS State Department of Health presentations on the Chronic Disease Self-Management Model at all DMH conferences. In both 2013 and 2015, the MS State Department of Health invited DMH to partner with them to develop conference content which included a full Behavioral Health track.

The DMH and the IWG have actively collaborated with other organizations and state agencies on potential projects and grant opportunities. These collaborative partners include the MS Primary Health Care Association, the MS Rural Health Association, the MS Association of Community Mental Health Centers, the Division of Medicaid, the Mississippi State Department of Health, Pine Belt Mental Healthcare Resources, Warren-Yazoo Mental Health Services, the University of Southern Mississippi, the University of Mississippi Medical Center and various Community Health Centers (FQHCs). In addition, DMH has actively pursued technical assistance available through the SAMHSA/HRSA Center for Integrated Health Solutions (CIHS). In 2014, DMH submitted an application to CIHS for participation in an Innovation Community entitled, Building Integrated Behavioral Health in a Primary Care Setting. DMH was awarded membership in this prestigious learning collaborative. In order to participate fully, DMH is overseeing two Case Studies: one with Jackson-Hinds Comprehensive Health Center (FQHC); and the second with Hinds Behavioral Health Services (CMHC). Both programs are working to provide integrated care services. The IWG serves as the Core Implementation Team for the project. Participation in the CIHS Innovation Community will conclude in August 2015.

In 2010, the MS Division of Medicaid applied for and received planning funding for development of a State Plan Amendment for Health Homes. Medicaid did receive planning funds for development of this SPA but, to date, no further information is available. There has been no collaboration with the DMH concerning this planning project. However, DMH plans to seek collaboration with the Division of Medicaid in consideration of an application for SAMHSA's Planning Grant for Certified Community Behavioral Health Clinics (application deadline of August 5, 2015).

The DMH has worked collaboratively with a number of other entities to develop initiatives for funding through various grant opportunities. In 2011, the DMH submitted a SAMHSA/ NASMHPD Transformation Transfer Initiative (TTI) grant application entitled *Mississippi Health Integration Readiness Initiative*. This initiative included funding for assessment activities and for a statewide Summit on Behavioral Health and Primary Care Integration. It was not selected for an award. Also in 2011 and early 2012, the DMH partnered with the University of MS Medical Center to submit a CMS Health Care Innovation Challenge Grant entitled *MS Health Linkages Expansion Project*. It would have expanded UMC's existing Tele-Health Network, including Community Mental Health Centers. It was not selected for an award. In 2012 and again in 2015, the DMH actively promoted SAMHSA's Primary and Behavioral Health Care Integration (PBHCI) grant. Submitted applications would have provided for primary care services to be made available through the Community Mental Health Centers, in most cases, through collaboration with the local Community Health Centers (FQHCs). Although several Community Mental Health Centers submitted applications each time, none of them were funded. Although none of these grant applications were successful, the opportunities for collaboration and relationship-building have been extremely valuable. The DMH will continue to take advantage of future opportunities to develop new initiatives with other agencies/entities.

The DMH is actively supporting a program at the University of Southern Mississippi's School of Social Work to expand behavioral health delivery capacity in primary care settings. Social Work and Psychology students are placed in Coastal Family Health (FQHC) and in field offices to provide direct services and coordinate care. Also, a professional development model for training for integrated care and a Training Institute will be developed. This program is funded through British Petroleum (BP) funding.

In March 2013, the DMH hosted a Spring Symposium entitled Improving *Quality of Life through Integrating Primary Care and Behavioral Health.* This day-long event was an effort to reach Physicians, Psychiatrists, Nurse Practitioners, Physician Assistants and Psychologists with information concerning the integration of primary, mental health and addiction services.

The DMH has funded the development of eight PACT (Programs of Assertive Community Treatment) Teams which include therapists (mental health, substance abuse and rehabilitation), nursing, psychiatry, case management and peer support (Certified Peer Specialists). The DMH requested additional funding from the MS State Legislature in 2012. Subsequently, DMH received special funding for four additional PACT Teams in FY15. Additionally, MS Medicaid provided the DMH with Balance Incentive Program (BIP) funding which supported the development of two additional PACT Teams in FY15. The DMH plans to continue to request additional funds.

The DMH is also a key participant with the Gulf Region Health Outreach Program's Primary Care Capacity Project. This is program is funded by British Petroleum (BP). The purpose of this project is to strengthen healthcare in Gulf Coast communities in Mississippi, as well as in Louisiana, Alabama and the Florida panhandle. Still in its early stages, this project provides the DMH with an opportunity to highlight the need for incorporation of behavioral health and patient-centered care.

Collaboration continues between the DMH, the MS Office of Tobacco Control, the MS Department of Rehabilitation and the University of Southern Mississippi's Institute for Disability Studies to minimize the usage of tobacco products in Mississippi. Thanks, in part, to this collaboration, use of tobacco products among younger Mississippians is at historic lows.

The DMH has partnered with the MS Office of Tobacco Control to develop a tobacco utilization survey for use with mental health services consumers and alcohol and drug treatment facilities statewide. Its purpose is to better understand at what age a person is likely to smoke and what variables are in place to trigger first-time use. The survey will also collect data which will be used to identify the characteristics of tobacco users, the frequency of tobacco use, and how staff members can deliver alcohol and drug cessation and prevention services.

In addition, the DMH is working with the MS Office of Tobacco Control to develop public education materials about tobacco prevention to place in waiting rooms and in group therapy rooms. Plans are also in the early stages to develop a Policy Academy to address tobacco cessation among individuals with mental illness and/or addictions.

Health information is obtained for all individuals seeking services from the DMH certified providers on the Initial Assessment. A medical examination is required for individuals in supervised and residential programs, as well as in senior psychosocial programs. Also, Certified Peer Support Specialists are trained to assist individuals receiving services in accessing all health care services. Presently, integrated mental health, substance abuse and primary health care services are not all available at the same location on a statewide basis. Seven Community Mental Health Center regions report being equipped for Tele-Health services; six of the regions utilize Tele-Health to provide services such as psychiatric evaluations and medication monitoring. Four Community Mental Health Centers report working directly with their local Community Health Center to provide primary care and other medical services; two of those Community Mental Health Centers have a formal agreement with the Community Health Center. One Community Mental Health Center reports that they provide primary health care services at the CMHC. Region 3 Mental Health Center located in Tupelo, Mississippi, serves seven counties and is a comprehensive health system. As with all CMHCs in the state, Region 3 offers a complete array of mental health and substance abuse services for SMI Adults and SED children/adolescents. In March 2014, Region 3 opened a new ten thousand square foot building devoted to the co-location and integration of primary health care and behavioral health care services. Included in this facility is a pharmacy which provides both medical and psychotropic medication for all its clients. Additionally, Region 3 operates a mobile primary care unit which travels to four counties in its region.

2. Health Disparities

The Cultural Competency Plan Implementation Workgroup recommended inclusion of language and proficiency in the DMH data collection standards including questions regarding primary language spoken by the individual, language preferred by the individual, language written by the individual, and whether or not the individual receiving services needed an interpreter. Due to funding constraints, the Workgroup was informed that additional questions to the current data collection system are currently not possible. Changes to the CDR required funding to conduct training on the data collection process with providers. Unless federally mandated, changes to the data collection system are not possible. At present, the Department of Mental Health is not collecting data on the LGBTQ population. When cultural competency trainings are conducted in the state, the Cultural and Linguistic Competency Training Evaluation form includes a sexual orientation question. The data from the form is placed in a comprehensive report for the training results. The DMH Central Data Repository collects profiles of persons served in the public mental

health system including age, gender, and race/ethnicity. Services received, income, educational attainment and mode of pay can also be collected.

The current DMH Central Data Repository does not address or track language needs. Language needs are addressed by creating a comprehensive list of translators and interpreters in Mississippi as well as a list of resources for alternate forms of communication for individuals with hearing, visual and/ or other disabilities. These two lists have been mailed to programs to assist with providing language needs. The DMH Operational Standards Rule 14.3 A-F Cultural Competency/Limited English Proficiency Services align with the mandated standards (4-7) in the 2012 CLAS Standards (National Standards on Culturally and Linguistically Appropriate Services) from the Office of Minority Health. The CLAS mandates (4-7) are current federal requirements for all recipients of federal funds.

Hiring a skilled evaluator to monitor access, service use and outcomes would be helpful in reducing disparities. Reviewing the national disparities that exist in the system and comparing them to the disparities currently existing in Mississippi would also be helpful. Mississippi began work on the development of a survey for service providers asking them to identify what disparities exist in their community.

4. Prevention for Serious Mental Illness

In FY13 DMH used some of the British Petroleum grant monies to certify approximately 10 DMH staff as trainers in Mental Health First Aid (MHFA). These trainers have provided much training throughout the state in FY14 & FY15. The DMH staff has trained staff from the MS Department of Education, including local school districts, local police precincts, the MS Department of Rehabilitation Services and the CMHC mobile crisis response teams at each of the 14 CMHC regions. MHFA training will continue to enhance the progress that has already been made. Communities who have a better understanding of mental health issues are shown to display less stigma around mental illness. Hopefully, with more community understanding, those who suffer from mental illness will receive assistance and support from our schools, churches and the general public. The DMH will continue to provide this service in FY16.

5. Evidence-Based Practices for Early Intervention (5 Percent)

In its FY 2014 appropriation, SAMHSA was directed to require that states set aside five percent of their MHBG allocation to support evidence-based programs that provide treatment to those with early SMI including but not limited to psychosis at any age. *Recovery After an Initial Schizophrenia Episode (RAISE)* initiative76 SAMHSA worked collaboratively with the NIMH to review evidence-showing efficacy of specific practices in ameliorating SMI and promoting improved functioning. NIMH has released information on Components of Coordinated Specialty Care (CSC) for First Episode Psychosis. Results from the NIMH funded 77, a research project of the NIMH, suggest that mental health providers across multiple disciplines can learn the principles of CSC for First Episode of Psychosis (FEP), and apply these skills to engage and treat persons in the early stages of psychotic illness. At its core, CSC is a collaborative, recovery-oriented approach involving clients, treatment team members, and when appropriate, relatives, as active participants. The CSC components emphasize outreach, low-dosage medications, supported employment and supported education, case management, and family psycho-education. It also emphasizes shared decision-making as a means to address individuals' with FEP unique needs, preferences, and recovery goals. Collaborative treatment planning in CSC is a respectful and effective means for establishing a positive therapeutic alliance and maintaining engagement with clients and their family members over time. Peer supports can also be an enhancement on this model. Many also braid funding from several sources to expand service capacity. States can implement models across a continuum that have demonstrated efficacy, including the range of services and principles

identified by NIMH. Using these principles, regardless of the amount of investment, and with leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, every state will be able to begin to move their system toward earlier intervention, or enhance the services already being implemented. It is expected that the states' capacity to implement this programming will vary based on the actual funding from the five percent allocation. States should be reviewing their data collection efforts related to demonstrating the effectiveness of the programs for the targeted population. SAMHSA continues to provide additional technical assistance and guidance on the expectations for data collection and reporting. Describe the state's assessed need for the target population and proposed evidence-based programs; provide an explanation for why this population was chosen, a description of planned activities, and a budget showing how the set-aside will be spent.

Please consider the following items as a guide when preparing the description of the state's system:
1. Identify a specific diagnostic category (i.e. psychosis, schizophrenia, bipolar, etc.).
2. Describe the evidence-based programs using the set-aside.
3. Are there alternative uses of the funds other than EBP's (i.e. staff development, regional plan, etc.) to support this required funding?
4. Describe the data collection efforts being used to demonstrate the effectiveness of the programs for this targeted population.

The Department of Mental Health subgranted Mississippi's portion of the five percent set aside to Community Mental Health Center Region 6/Life Help. Life Help, the largest Community Mental Health Center in the state serves 12 of 82 counties where 47.1% of children are in poverty. Approximately, 15% of the population in this region is ages 15-24 years of age, making this a priority group for early intervention. The target population for this initiative is youth/young adults ages 15- 30 years of age who have experienced a first episode of psychosis inclusive of diagnosis in the schizophrenia spectrum and other psychotic disorders. During FY 2014, a Coordinated Specialty Care Team was identified and trained using the NAVIGATE program that was created under the RAISE initiative. DMH contracted with NAVIGATE consultants, Susan Gingerich, Dr. Shirley Glynn, and Dr. Delbert Robinson to provide training and technical assistance to the CSC team. Two on-site trainings were provided to learn about the roles of the individual team members: Team Leader, Prescriber, Individual Resiliency Trainer, Family Education Clinician, Supported Employment and Education Specialist and Case Manager. The NAVIGATE consultant team continues to provide bi-monthly technical assistance phones calls to review roles, manuals, discuss youth referred, provide input and guidance on further program development. The CRC is actively serving three (3) young adults who are being seen several times throughout the week, invited to come to group meetings, social outings, and connected to other resources in the community. CSC Team education and meetings are held every other week, with the goal of obtaining one (1) referral each month for for FY 2015. Ongoing training, education and outreach to referral sources continue each month. Program specific data collection and measurements are under development. A NAVIGATE satisfaction survey will be administered quarterly to individuals in the program.

7. Program Integrity

Specific grant requirements are conveyed to Department of Mental Health service providers during the RFP process. Additionally, service providers are required to sign a packet of applicable agreements including both a list of "Federal Assurances" and Mississippi Department of Mental Health Assurances on an annual basis. Any additional requirements specific to grant funding are included in this annual packet to be signed by the program administrator annually.

Budgets are reviewed prior to awarding funds during the sub-grant application process by both programmatic staff and financial staff. Items requested by potential service providers that do not

meet the programmatic intention of the grant funds or do not meet the "necessary and reasonable" test from the financial review are removed from the amount awarded unless the service provider can demonstrate otherwise.

The Mississippi Department of Mental Health operates on a reimbursement payment system. Cash requests are submitted monthly by sub-grant recipients with specific items requested by category (salaries/fringe, contractual, commodities, equipment) for reimbursement. These requests are reviewed by grants management staff, accounts payable staff, and programmatic staff to insure items requested to be reimbursed are within the approved budget justification. The state accounting system prevents any service provider from being paid in excess of their budget award.

The Department of Mental Health has an Audit Division with two major functions:
1) Conduct annual compliance audits of grant sub-recipients. Grant audits include tracing expenditures reimbursed through monthly reimbursement requests through invoices, bank statements, rental agreements, ledgers, etc. Audit procedures are outlined in the agencies "Central Office Audit Guide."
2) Review independent audit reports submitted annually by grant sub-recipients. All DMH service providers receiving grant funding are required to have a financial statement audit. This audit has to be in compliance with OMB A-133 (Single Audit) if applicable. The DMH Audit staff review these audit reports and follow up on any findings noted therein. Grant guidelines, reimbursement instructions, independent audit requirements, federal and state grant requirements, as well as links to Federal cost circulars are included in our agencies "Service Providers Manual" that is available on-line on the Mississippi Department of Mental Health website.

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8. Tribes

The Division of Children and Youth Services provides funding and coordination of learning collaboratives for Trauma-focused Cognitive Behavioral Therapy (TF-CBT) and Structured Psychotherapy for Adolescents Responding the Chronic Stress (SPARCS). This collaborative learning approach targets clinical/supervisory staff for intensive training in TF-CBT and SPARCS, followed by specified periods of implementation of standardized assessment and treatment approaches, during which the staff receive expert consultation through the project and peer support through focused staff meetings. Participants in the collaboratives have included clinicians from the 14 CMHCs and the MS Band of Choctaw Indians Behavioral Health. The Department of Mental Health continues to have an individual from the Choctaw Tribe participating on the Multicultural Task Force. The representative receives all correspondence related to the Multicultural Task Force. Staff from the Division of Children and Youth collaborated with a member from the Choctaw tribe about the 10th Annual Youth Leadership Conference that took place June 24-24, 2015. The DMH Division of Children and Youth staff conducted a presentation on "The Importance of Education" as it relates to the educational history of Native Americans, alcohol and drugs, self-esteem, mental illness and poverty. The speaker discussed the benefits of education for youth. Members of the Choctaw Tribe also participate in the annual Mississippi Day of Diversity initiative sponsored by the Department of Mental Health. In addition, youth from the NFusion programs in Philadelphia, Meridian, and Newton attended the 2015 Annual Youth Leadership Conference as well as staff from the DMH.

11. Quality Improvement Plan

The Bureau of Quality Management, Operations and Standards is responsible for the development of DMH standards of care for providers, provider certification and compliance with DMH standards, provision of support to programmatic divisions/bureaus with the DMH to assist with information management and reporting, oversight of agency and provider emergency management/disaster response systems to ensure continuity of operations within the public mental health system, management of the serious incident reporting system for DMH certified providers, operation of DMH's information and referral services, and oversight of constituency services. In order to carry out these functions, the Bureau of Quality Management, Operations and Standards is compromised of the Division of Certification, the Office of Consumer Support and the Office of Incident Management.

The Division of Certification is responsible for provider certification across the three populations served by the DMH – mental health, intellectual/developmental disabilities, and substance use. The DMH operates on a three year certification cycle to ensure that all DMH certified providers have an on-site compliance/certification visit at a minimum of twice during that certification cycle. In addition to the on-site compliance visits, the DMH regularly conducts visits to certified providers to certify additional new programs and services. The DMH does institute a CQI process as part of its monitoring. As issues of noncompliance are found at the provider level, the DMH provides notification of those issues and provides technical assistance as to how to correct those issues and maintain ongoing compliance. Providers develop plans of compliance to the DMH for approval and subsequent implementation. In turn, the DMH conducts follow up visits to ensure that corrective action is taken and remains ongoing. The DMH tracks all deficiencies to identify trends and patterns and make changes to policy as needed.

The Office of Incident Managements is responsible for both DMH's disaster response and preparedness activities and managing the serious incident reporting system utilized by the DMH certified providers. In responding to statewide emergencies, the DMH's Director of the Office of Incident Management serves as the liaison between the Department and the MS Emergency Management Agency. In the State's Comprehensive Emergency Management Plan, the DMH serves as a support agency for ESF 6, ESF 8 and ESF 15. The DMH maintains a statewide emergency response plan and continuity of operations plan. The DMH requires all certified providers to maintain both disaster/emergency response plans and continuity of operations plans specific to their local sites and emergency management/disaster response structures at the local level.

The DMH tracks and responds to serious or critical incidents. The DMH defined serious incidents which include categories such as: suspected abuse, neglect or exploitation, injury occurring at a program location, death, suicide attempt at a program location, elopement from a program, medication errors, etc. Certified providers are responsible for reporting serious incidents to the Office of Incident Management within 24 hours. The Office of Incident Management triages all reports, assigns a category of incident, and level for DMH response/follow-up. The Office of Incident Management conducts on-site follow up on serious incidents assigned a Level III. The Office of Incident Management also utilizes a CQI approach to its follow up process. As issues are found at the provider level, the DMH provides notification of those issues and provides technical assistance as to how to correct those issues. Providers develop and implement corrective action to prevent future occurrence.

The Office of Consumer Support is responsible for operating the state's grievance system. Individuals may report a grievance regarding the care of someone receiving services through the public mental health system. All certified programs are responsible for posting DMH's 1-877 line

in the program areas and incorporating the Office of Consumer Support into their local level grievance procedures that are shared with all people receiving services. Much like the serious incident management system, the Office of Consumer Support triages all grievances received, assigns a category of grievance and a level for DMH response/follow-up. The DMH's target for resolution of grievances is 30 days from the date filed.

12. Trauma

As required by the Department of Mental Health's Operational Standards, Mental Health Providers certified by the Department of Mental Health has integrated trauma screening practices into the initial intake assessment process for individuals receiving services. All new cases must have a Trauma screening with documentation in the individuals receiving services chart.

Since 2006, providers of children and youth mental health services in Mississippi are being trained in trauma-specific interventions such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) and Combined Parent-Child Cognitive Behavioral Therapy (CPC-CBT). To date, there are 351 TF-CBT Therapists, 95 SPARCS Therapists and 15 CPC-TFC Therapists.

Mississippi also has (3) three National Child Traumatic Stress Network Sites. They are Catholic Charities, Inc., Region 13/Gulf Coast Mental Health Center, and Wilson-Sigrest, LLC. In direct response to the needs from Hurricane Katrina, Mississippi was the 1st State to have a Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) state level Learning Collaborative coming out of National Child Traumatic Stress Network (NCTSN). In 2012 and 2013, the Department of Mental Health received Technical Assistance from SAMHSA's National Center of Trauma Informed Care. This included speakers for regional trainings and on-site visit to Mississippi State Hospital.

The Department of Mental Health, Division of Children and Youth Services continue to provide trauma-informed trainings to community and state partners including family members and caregivers. There have been over 30 learning sessions held, comprising a mix of small workgroups (e.g., 11 participants) and large workshops (e.g., 600 participants) to over 3500 participants connected to the MS System of Care. These also include keynote and breakout sessions at state conferences (e.g., System of Care, Corrections, Child Welfare, Juvenile Justice, Addiction, and Drug Court Education.)

Information obtained from 1,026 evaluation forms completed by participants at the conclusion of the learning sessions held indicated an increased knowledge of the four learning objectives. This number does not reflect the total number of participant as several did not complete evaluations due to various reasons including leaving before the end of the training or failing to return evaluation forms prior to leaving training. Participants were asked to compare their knowledge from Not Very Well to Very Well at the end of the training. **95%** of participants reported the training met their professional, personal and/or educational needs. **89%** of participants reported they could immediately apply the information in their practice, service setting and/or personal relationships.

In 2013, the Department of Mental Health, NFusion X (SOC site) and East MS State Hospital/Bradley Sanders Adolescent Complex (Psychiatric Hospital) participated in a one year Trauma Learning Collaborative with the National Council for Behavioral Healthcare. The collaborative consisted of webinars, consultation conference calls and face-to-face meetings.

The 6 Domains and Performance Standards addressed in the learning collaborate include:

- Early Screening and Comprehensive Assessment of Trauma
- Consumer Driven Care and Services

- Trauma Informed, Educated and Responsive Workforce
- Trauma Informed, Evidence-Based and Emerging Practices
- Create Safe and Secure Environment
- Engage in Community Outreach and Partnership Building

Highlights of the Learning Collaborative included:

- Implementation of the North Shore – Long Island Jewish History Checklist
- Staff Education and Training to over 150 East MS Staff
- Partnership with local system of care grantee to improve community outreach
- "Violence, Trauma and Healing: The Impact of Children and Families" workshop on 5/31/2014
- Revisiting policies for Alternative to Restraints and Seclusions, PRN Medications, and Staff Incidents involving patients
- 4 staff members completed in TF-CBT Learning Collaborates
- Blueprint for other psychiatric hospitals

In 2014, the Department of Mental Health held its first state-wide Trauma Conference. The "Trauma: The Silent Storm That Impacts Us ALL" Conference was held Tuesday, September 9th through Thursday, September 11, 2014 at the Jackson Convention Complex. The conference consisted of 5 Pre-Conference sessions, 28 breakout sessions, 6 plenary sessions and 1 Post Conference session. There were over 600 participants representing mental health and substance abuse professionals, educators, lawyers, law enforcement, first responders, homelessness, domestic violence and other advocacy agencies, peer support specialists, social workers from various agencies, juvenile justice, colleges and universities and many more.

Highlights of the conference included keynote presentations by:

- Kevin Hines, Author and Professional Speaker, who is one of 33 individuals who survived after jumping off the Golden Gate Bridge, and the only survivor who shares his story of recovery and hope. Accompanying Kevin Hines was Kevin Briggs. He retired from the California Highway Patrol after 23 years patrolling the Golden Gate Bridge. He shared strategies of how he successfully prevented more than 200 individuals from completing suicide but also retiring after he could not separate his job from his personal life.
- Coach Alfred Powell received a standing ovation following his innovative presentation, "My Trauma is My Drama." The presentation included the correlation between trauma, violence and undiagnosed mental health issues in the African American community.
- Mississippi's own experts, Dr. Kim Shackelford and Kelly Wilson also received rave reviews. Dr. Shackelford provided practical examples of preventing Secondary Traumatic Stress and the importance of self-care. Kelly Wilson closed the conference discussing the 12 core components of trauma referencing events in her life as examples of the core components.

The 2015 Trauma Conference is scheduled for September 16 -18th and will also include a Pre-Conference on September 15, 2015 for First Responders.

The Mississippi Department of Mental Health teamed up with the Mississippi National Guard to launch a mental health awareness campaign for the military and their families in 2011. The campaign, Operation Resiliency, reaches all National Guard units across the state. Operation Resiliency aims to dispel the stigma associated with mental illness, educate about mental health and stress, recognize signs of duress and share knowledge about available resources. The Department

of Mental Health provided materials to more than 12,000 Mississippi National Guard during Suicide Prevention Month – September 2011 – and continues to provide educational materials. In 2012, the campaign was expanded to VA Centers across the state. Campaign materials include a resource guide - which highlights what services are available in different parts of the state, brochure and poster with tear off cards. The materials focus on: what stress can lead to, dispelling stigma in order to increase help seeking behaviors, warning signs, how to handle stress, and knowledge about available resources. The posters were placed in restrooms at all Mississippi National Guard Units so people could tear off a "get help" card in private.

13. Criminal and Juvenile Justice

The MAYSI-2 is utilized by the youth courts and detention centers across the State of Mississippi in identifying youth, 12-17 years, who may have special mental health needs. It is administered upon intake for probation or detention. If the score alerts the youth intake worker for a more in-depth assessment, a referral is made to the local Community Mental Health Center. Ten (10) Community Mental Health Centers receive grant funds for Juvenile Outreach Programs which provide a range of services and supports for youth with SED involved in the juvenile justice system and/or local detention center. The program provides for immediate access to a Community Support Specialist or Certified Therapist for assessments, crisis intervention, medication monitoring, family therapy, individual therapy, linkages to other systems and resources that the youth and family may need.

The Department of Mental Health, Division of Children and Youth Services collaborates with the Division of Youth Services, Department of Human Services to implement Adolescent Opportunity Programs (AOP) in eight (8) Community Mental Health Centers across the state. AOPs are community-based partnerships that share resources and services to reduce the number of at-risk youth being placed in state custody. AOPs target adjudicated delinquent youth ages 12-17 years who are at high risk of becoming further involved in the criminal justice system. The program operates on a 12 month basis, until the youth completes all three phases of the program or completes his or her probation sentence. Services provided through the program include day treatment, group/individual/family therapy, recreational therapy, parent/caregiver education, and life skills coaching. The DMH, Division of Children and Youth Services staff actively participates in the Juvenile Detention Alternatives Initiative (JDAI) through the Office of the Attorney General funded by the Annie E. Casey Foundation. This initiative has been implemented in five (5) counties with youth detention centers and plans are being developed to implement the JDAI principles state-wide.

16. Crisis Services

The MS DMH provides approximately $4,750,000 to the 14 CMHC's in MS to provide crisis response services. These crisis services provide a 24 hour/7 day a week toll-free crisis phone line for each of the CMHC's regions. The calls received by the crisis phone line are triaged for severity. Some calls can be handled by the staff person answering the call but the more severe needs are referred to a mobile crisis response team. Each CMHC region is required to provide mobile response services in every county they serve. The mobile crisis response teams must be able to respond with one hour in an urban area and within two hours in a rural area. The mobile crisis response teams are required to have a Master's level therapist, a Certified Peer Support Specialist (CPSS) and a Community Support Specialist (case manager) as part of the response capacity. Additionally, if the mobile crisis response team must respond in an area that may not be safe, the will have law enforcement accompany them. A strong working relationship with law enforcement is required through the grant funding. The mobile crisis response team will triage during the face-to-face contact to determine the severity of the needs of the individual. If the person in crisis is unable to stay in the community due to the severity of the crisis, then the mobile crisis response team facilitates or provides transportation to a crisis stabilization unit or local hospital with

psychiatric care available. The mobile crisis response team is also required to develop working relationships with all emergency departments within their catchment area and can respond to calls from the emergency department. The mobile crisis response team is also tasked to follow-up within 24 hours of a face-to-face contact with an appointment at the CMHC. The "warm-handoff" model is used to facilitate services for the person in crisis with the next provider. Additionally, the mobile crisis response team provides crisis prevention services by following all individuals discharged from a DMH behavior health program or a crisis stabilization unit until the person can successfully reenter "regular" services with the CMHC or other provider. All individuals receiving services at a CMHC who has recently been discharged from a DMH behavioral health program or from a crisis stabilization unit must have a Crisis Support Plan put in place. All individuals who have received face-to-face contact from the mobile crisis response team are also required to have a Crisis Support Plan put into place. The Crisis Support Plan is developed with the individual, CMCH staff and any significant others the individual wants involved. The individual is able to design a plan for how they want to be treated the next time they are in crisis which the CMHC staff and others, such as law enforcement, chancery court, etc… can follow in the event of a subsequent crisis. As part of the crisis response system, the CMHC's are required to develop a multi-disciplinary assessment and planning team (Map Team) made up of all the agencies that work with the most well-known individuals in the community. The Map Teams usually consists of mental health, health, human services, police department, sheriff's office, chancery clerk, faith based ministries, housing, etc… to develop a plan for the individuals in their community which consume the most time from all these agencies. The Map Teams are encouraged to find an alternative to continually committing the same individuals over and over to one of the State behavioral health programs. DMH has also formed a partnership with the Lauderdale Sheriff's Office to develop Crisis Intervention Teams (CIT)) across the state. The Lauderdale Sheriff's Office is a training site for officers from anywhere in the state to come the 40-hour training required to be a CIT officer. The local CMHC is fully involved in the curriculum development and presentation. The mobile crisis response coordinators in each CMHC region assist with the development of CIT in their respective CMHC regions.

DMH would like technical assistance with Wellness Recovery Action Plan (WRAP) crisis planning, Peer-operated warm lines, peer-run crisis respite programs, and the Living Room Model.

17. Recovery

The Mississippi Department of Mental Health has adopted the philosophy that "all components of the system should be person-driven, family-centered, community-based, results and recovery/resiliency oriented" as highlighted in the Mississippi Board of Mental Health and Mississippi Department of Mental Health Strategic Plan. The FY16 – FY18 DMH Strategic Plan includes objectives focused on utilizing peers and family members to provide varying supports to assist individuals in regaining control of their lives and their recovery progress. These objectives are met through the Certified Peer Support Specialist Program, recovery-oriented system of care trainings, Personal Outcome Measures (POM), and other activities. The Plan also includes strategies to increase the use of Wellness Recovery Action Plans (WRAP) and Whole Health Action Management (WHAM) at DMH's behavioral health programs. In 2014, DMH established a Division of Recovery and Resiliency within the Bureau of Outreach, Planning and Development. The Division administers the Certified Peer Support Specialist Program for people who have lived experience of mental illness and/or substance use disorder and/or family members who want to provide peer recovery services to others. The Division is responsible for implementing the Think Recovery awareness campaign and moving the public mental health system towards a recovery-oriented system of care.

Involvement of Individuals and Families

Recovery is based on the involvement of consumers/peers and their family members. States must work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. Efforts to actively engage individuals and families in developing, implementing and monitoring the state mental health system include:

> **Planning Services –** Consumers and family members have an opportunity for meaningful participation on planning councils, task forces and work groups on a state, local, and national level.
>
> **Delivery of Services –** Consumers and family members are employed as certified peer support specialist and/or peer support specialist.
>
> **Evaluation of Services –** Consumers and family members have an opportunity to participate on personal outcome measure interviews using the Council on Quality of Life Personal Outcome Measures. The personal outcome measure interviews provide an opportunity for consumers and family members, through a guided conversation, to evaluate quality of life. Consumers and Family members, on a local level are involved in consumer and family satisfaction surveys.

The DMH sponsors meetings with peer support specialists and certified peer support specialists to discuss the role of peer support and barriers to provision of peer support services within the behavioral health service system. The DMH also sponsors Mental Health Planning Councils and various task forces, work groups and committees as an avenue to address issues and needs regarding the behavioral health service system.

Individuals and family members are presented with opportunities to proactively engage the behavioral health service delivery system; participate in treatment and recovery planning; shared decision making; and direct their ongoing care through the Breakthrough Series. The DMH provides trainings to peer specialists and is working with advocacy groups, consumers and family members to develop a system that affords consumers and family members the opportunity for meaningful participation in treatment, service delivery system, etc.

Based on the 2014 Advisory Council Survey, individuals and family members are in leadership positions within our state planning councils. Specifically, the Chairperson of two of the state's four Planning Councils is either a family member or individual receiving services. As a result of the survey, DMH hosted a Leadership Academy in May to offer individualized training for 25 people to focus on how to expand their current role and serve on taskforces, workgroups, etc.

Housing

Included in the DMH Strategic Plan are several objectives and strategies for improving and expanding housing opportunities that will enable more individuals to be served effectively in fully integrated community living. During calendar year 2012, a significant DMH Strategic Plan benchmark was achieved with the establishment of a DMH Division of Housing and Community Living and appointed a full-time director of this new Division. In order to be successful in addressing housing needs of persons served, additional Strategic Plan objectives include increasing the percentage of funding allocation to housing as a priority service as well as seeking to provide a full array of supported housing services in communities throughout the state. In the FY16 – FY18 DMH Strategic Plan, the agency will focus on increasing the availability of community

supports/services for people with SMI in order to implement the Permanent Supportive Housing model.

The DMH realizes that in order for individuals served to live successfully in the community, a full array of supportive services needs to be developed and maintained. This is also addressed in the DMH Strategic Plan with an objective to provide community supports for persons transitioning to the community through participation in the Mississippi Division of Medicaid's Money Follows the Person (MFP) demonstration project. Within the scope of the MPF project, the DMH is actively implementing a plan to expand Medicaid-funded Waiver Services to enable individuals with IDD to transition from DMH residential programs to fully integrated community living. In conjunction with the expansion of Waiver Services, there is specific funding in MFP for specific, time-limited costs associated with helping individuals successfully transition to the community of their choice.

Another transition-related benchmark involves establishing inter-agency, multidisciplinary teams at the state residential programs to assist individuals in making a seamless transition to living in the community. Each DMH residential program has hired or appointed a Transition Coordinator to oversee and manage the transition activities at each program and to work with the transition team at each program.

Certified Peer Support Specialist Program

The DMH's Peer Support Specialist Program began in 2012. Since then, a total of 165 people have been trained and 118 are Certified Peer Support Specialists (CPSS). CPSSs are required to have 20 hours of continuing education. A CPSS is a family member and/or individual who has self-identified as having received or is presently receiving behavioral health services. Additionally, a CPSS has successfully completed formal training recognized by the DMH and is employed by a DMH Certified Provider. These individuals use their lived experience in combination with skills training to support peers and/or family members with similar experiences. CPSSs support their peers both individually and in groups. Under general supervision, a CPSS performs a wide range of tasks to assist individuals to regain control of their lives and their own recovery and resiliency journey. CPSSs provide varying supports, some of which might be offered by others in the behavioral health system, but CPSSs contribute something unique. They are living proof that recovery is possible. CPSSs share lived experiences and are willing to share their stories to benefit others.

The DMH is also focused on a training program for family and parents of children with behavioral disorders defined as a Serious Emotional Disturbance (SED). Currently, there are six (6) CPSSs that identify as a parent or caregiver of a youth with SED. However, DMH and those CPSSs realize that a more specified training is needed for those family and parents who wish to work with families that are experiencing mental health challenges with their children. The DMH is working to develop a curriculum focusing on training for a Certified Parent/Caregiver Support Specialist.

The DMH contracts with eight CPSSs and one CPSS Supervisor, who serve as CPSS Ambassadors, to provide technical assistance to providers, to provide support to other CPSSs, and to conduct trainings across the state. DMH worked with the Ambassadors to create two toolkits – a CPSS Provider Toolkit (for providers interested in employing a CPSS or who want to learn more about how to utilize a CPSS) and a CPSS Toolkit (for individuals who are interested in becoming a CPSS). In collaboration with CPSS Ambassadors, DMH developed a PowerPoint based on the CPSS Provider Toolkit. The training targets the following: 1) Organizations who already employ CPSSs; 2) Organizations who have decided to employ CPSSs and would like to know how to introduce them successfully into the workplace; 3) Organizations thinking about employing CPSSs.

The DMH has monthly calls with CPSSs and Peer Support Specialists to look at employment opportunities, training opportunities, and other valuable information.

Personal Stories of Recovery
The DMH saw the need for people to share their own personal stories of recovery to help inspire both providers and other individuals on their road to recovery. DMH has filmed more than 25 videos of people sharing their stories. DMH also filmed two CPSSs talking about the benefits of employing CPSSs and two CPSS supervisors sharing the difference CPSSs have made in their organizations. All videos are on DMH's Web site and one video each highlighted monthly via e-mail. The DMH also partners with NAMI-MS to host a Share Your Story Workshop twice a year to provide tips on how to effectively tell your recovery story.

Drop-In Center
The Mental Health Association of South Mississippi Opal Smith Drop-In Center offers a day program for adults with mental illness and people with disabilities. Instead of being alone, people fill their day with arts, crafts and games, making friends, and gaining confidence. At the Center, they can explore personal interests in a safe, non-judgmental way and learn to become more independent in a recovery-oriented environment. The Center also develops Wellness Recovery Action Plan (WRAP) with people who come to the Center.

Supported Employment
The DMH has developed and made available supported employment services based on the Substance Abuse and Mental Health Services Administration's Evidence-Based Practice for Supported Employment and Dartmouth Individual Placement and Supports Model (IPS). In 2015, DMH began implementation of this program with four pilot program sites operated through the Community Mental Health Centers in Region 2, Region 7, Region 10 and Region 12. These services are available for adults living with mental illness, and DMH will be collaborating with the Mississippi Department of Rehabilitation Services to leverage each agency's ability to provide employment supports.

Internal Training and Outreach
The DMH distributed an internal survey to Central Office staff to gauge their understanding of recovery. As a result of the survey, DMH employees at all levels within the agency participated in a mandatory training to provide a better understanding of the ongoing transition to a recovery-oriented system of care. DMH's newly established Division of Recovery and Resiliency led the training sessions, but they did so with the help of the CPSS Ambassadors. CPSSs shared how they have been directly impacted by their own or their loved ones' struggle with mental illness. They walked DMH staff through each of the Components of Recovery. DMH staff marveled at their presentation skills and their courage to share personal information in order to help all employees understand the need and value in continuing to move toward a recovery-oriented system of care.

18. Community Living and the Implementation of Olmstead
States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

A Statewide Approach for Integrated Supportive Housing in Mississippi
In June 2013, the Department of Mental Health facilitated a SAMHSA-sponsored Olmstead Policy Academy to help Mississippi develop action plans to increase community integration for people with behavioral health issues. With the help of a lead facilitator assigned to us by SAMHSA, a Mississippi team spent several months developing a one-year action plan with goals and strategies

to help us promote community integration through improved housing, employment, and recovery support opportunities for people with behavioral health disorders in Mississippi. The team was made up of approximately 30 individuals representing service providers, policy makers, and stakeholders in the targeted areas of housing, employment, and recovery support. The *Olmstead* Policy Academy Strategic Plan that resulted from the efforts of the Policy Academy members identified goals, strategies, and activities for each of the three critical areas included in the plan that ultimately led to the development in 2014 of a more comprehensive, targeted state plan for statewide systematic approach to addressing the requirements of *Olmstead* and Title II of the ADA.

Multiple agencies, including development authorities, housing corporations, regional housing authorities, state departments, federally funded contractors and local contracted providers have a role in providing housing and supportive services for individuals with disabilities and life challenges in the State of Mississippi. In 2014, the State of Mississippi, through an appropriation to the Mississippi Department of Mental Health (MDMH), engaged in the development a statewide integrated, supportive housing (ISH) strategy for people with mental illness, intellectual and developmental disabilities (IDD), addictive disease, Veterans and other high need populations in Mississippi served by agencies such as the Department of Human Services (DHS), Department of Health (DOH), and the Department of Corrections (DOC). ISH refers to safe, secure and affordable housing, where tenancy is not time-limited as long as the resident pays the rent and honors the conditions of the lease. Individualized and flexible support services are available to residents based upon their choices and needs.

As part of this process, a strategic planning committee was convened to discuss and identify the challenges and barriers to the availability of supportive housing, and to make recommendations for an organized, statewide supportive housing strategy. Membership of the planning committee consisted of leadership from key state agencies that work with Mississippians who may be in need of supportive housing. Available sources of information pertaining to federal, state and local resources and affordable housing policy in Mississippi was also reviewed, as well as approaches that other states have taken to organize management of supportive housing resources for people with disabilities and other target populations. Key stakeholders and other informants were interviewed about possible housing strategies, including staff from state agencies, service providers, housing developers, public housing authorities, and service recipients. These efforts revealed that: 1) that the State of Mississippi has human service agencies (MDMH, DHS, DOH, DOC, etc.) with the expertise to provide services to individuals with disabilities and life challenges, however, these agencies do not have the expertise to create and provide affordable housing stock to scale; and 2) Mississippi needs a single designated agency to coordinate housing efforts statewide.

Three key issues were identified that Mississippi should address to improve its ability to meet the integrated, supportive housing needs of people with disabilities or other priority populations:

1. The lack of a coordinated integrated, supportive housing strategy across State agencies is resulting in missed opportunities to increase affordable housing;

2. There are limited housing resources currently available to meet the affordable housing needs of the State's low income disabled population and other priority populations; and

3. An assessment is needed of the types of services that should be provided to ensure the success of individuals who gain access to integrated supportive housing opportunities.

With limited affordable housing options, many individuals with disabilities and life challenges have had little choice but to live in the limited housing options they could afford, often in less than desirable settings, in un-safe neighborhoods or in more restrictive settings. Others with involved

families have had to return to live with them, in some cases losing the instrumental activities of daily living (IADLs) skills they may have acquired while in more independent living and in other cases affirming their families' angst over what would become of them when the families are no longer able to provide them a place to live. The recommendations below were informed by numerous interviews with stakeholders representing the continuum of housing and service agencies. There were consistent messages about the strengths and shortcomings of the current system that need to be addressed and can be built upon to create recommendations for integrated, supportive housing opportunities.

1) Designate the Mississippi Home Corporation (MHC) as the lead agency for the statewide housing strategy. As Mississippi's designated Housing Finance Agency, MHC is the only agency in Mississippi where housing is its core mission.

2) The Mississippi Legislature should establish an ongoing interagency housing council and define its role. The ISH Planning Committee could serve as the starting point, adding a few additional tactical members. The objective is to create a body that is responsible and accountable for housing resources and the policy needed to most effectively use those resources. The council should be charged with developing an integrated, supportive housing plan and submitting an annual progress report.

3) The Mississippi Legislature should develop and appropriate funds for a state-funded bridge housing subsidy program (HSP). The HSP should be designed to resemble the federal Housing Choice Voucher (HCV) program, and all participants should be required to apply for and transition to a form of federal rental assistance when possible. Individuals who could be eligible for the HSP should be specified in program requirements and should include people with disabilities or other priority populations served by human service agencies such as MDMH, DOM, DHS, DOH and DOC. The HSP should be administered by MHC in coordination with the relevant State agencies.

4) Create and appropriate funds for an ISH Coordinator position to be housed at the Mississippi Home Corporation. The responsibilities for administering and coordinating housing resources across multiple agencies are time-consuming and complex. Allocating these responsibilities to existing staff would result in an ineffective housing strategy.

5) Create and appropriate funds for Housing Support Specialists to assist individuals supported by the bridge housing subsidy program with pre-tenancy and post-tenancy activities.

6) Obtain specific housing needs data for targeted subpopulations and establish criteria for who is in need of integrated supportive housing. While each agency may have some data on the housing needs of individuals the agency serves, there is not a mechanism for aggregating and un-duplicating data across agencies to create a valid and reliable data set. This activity will require clearly defining the target population(s) and establishing criteria for who is in need of ISH.

7) Initiate immediate planning for the U.S. Department of Housing and Urban Development (HUD) FY 2015 811 Project Rental Assistance (PRA) application. PRA funds are awarded to State Housing Finance Agencies to create deeply affordable supportive housing units for people with disabilities within mainstream affordable housing (either existing or to be established) developments financed by the State

Housing Agency through programs such as the Low Income Housing Tax Credit (LIHTC) program, the HOME program, state bond financing, etc.

8) Identify additional housing resources with potential to adopt a disability and homeless preference in accordance with HUD guidance. For example, in July 2013, HUD issued Notice H: 2013-21 in which it clarified that private owners of HUD-assisted Section 8 project based assistance could request a homeless preference from HUD. As such, private owners and developers whose properties have Section 8 project based assistance can request a preference from HUD to serve homeless persons. The new ISH Housing Coordinator could convene meetings of owners of such Section 8 HUD-assisted housing to identify a strategy for Mississippi.

9) Work with Public Housing Authorities (PHAs) to establish an Olmstead preference, thereby increasing the possibility that people with disabilities who may be part of an Olmstead class are more likely to access federal rental assistance.

10) Evaluate the adequacy of existing services and funding for services, as well as the need for alternative approaches, to ensure the success of individuals who gain access to supportive housing.

Additional resources will be needed if Mississippi is to commit to a *sustainable pipeline* of integrated, affordable housing and services to meet the need of individuals with disabilities.
(Portions of the information Excerpt from the full report prepared by TAC: *A Statewide Approach for Integrated Supportive Housing in Mississippi, October 2014)*

During Mississippi's Legislative session that ended in April 2015, a bill was passed and signed by the Governor to fund a State Bridge Subsidy voucher targeted to individuals identified in Olmstead and included in a joint agreement letter dated August 29, 2014 between the US Department of Justice and the Attorney General of Mississippi. Implementation of the new state-funded bridge subsidy program will be administered by the MS Home Corporation (MHC) which is Mississippi's Housing Finance Agency in direct partnership with the MS Department of Mental Health (MDMH) and with active participation by the state's Community Mental Health Centers (CMHC). Each partner entity will identify a Point of Contact to be primarily responsible for managing he process for transitioning individuals from a state hospital to the community. Here are the usual steps in the transition process:

1. Hospital POC will send discharge/referral information to POC at MDMH.
2. POC at MDMH will contact POC at CMHC to initiate the process.
3. A VI-SPDAT screening to identify level and type of housing needed will be completed.
4. CMHC will contact MHC to enroll the individual in the MHC Bridge Subsidy program.
5. The State hospital POC will coordinate the individual's discharge to the community with the CMHC.
6. If MHC Bridge Subsidy is not available at the time of discharge, CMHC will develop/implement a temporary housing and services plan until a slot in the MHC Bridge Subsidy program is available.
7. CMHC and MHC will coordinate transition from temporary housing setting to a Permanent Supportive Housing setting when slot becomes available. CMHC supportive services will continue.

19. Children and Adolescent Behavioral Health Services

The Mississippi Transitional Outreach Project (MTOP), a six-year CMHI Cooperative Agreement and Project XPand, a four-year System of Care implementation initiative created the Executive Steering Committee to provide interagency state-level input and direction to the local programs

implementing the programs. In FY 13, the Bureau of Alcohol and Drug Abuse Services was awarded a State Adolescent Treatment Enhancement and Dissemination (SYT-ED) grant. State and local level project staff joined the Executive Steering Committee to incorporate plans for assessments and services to youth with SED and substance use disorders. The Executive Steering Committee meets monthly to share updates on the implementation of evidence-based practices, policy and procedures revision, programming, evaluation and data reports. Additionally, the DMH's Bureau of Alcohol and Drug Abuse Services and Division of Children & Youth Services are part of SAMHSA's Transforming, Linking and Coordinating for Youth (TLC-Y) initiative as both CMHS and CSAT grantees. States part of the TLC-Y initiative receive technical assistant on coordinating efforts between both grants serving youth/young adults including financing a continuum of effective assessment, treatment and support services for youth/young adults with SED and substance abuse disorders.

Guidelines for individualized care planning for children and youth with mental, substance use and co-occurring disorders have already been established through the DMH Operational Standards and the DMH Record Guide. The DMH certified providers utilize an Individualized Service Plan that includes strengths, long term and short term goals, objectives and outcomes. For those youth with co-occurring disorders, a substance abuse specific assessment is also utilized in addition to the initial assessment.

The Interagency Coordinating Council for Children and Youth and the Interagency System of Care Council (ISCC) have representatives of the Department of Human Services, Division of Youth Services (juvenile justice), Department of Human Services, Division of Family and Children Services (child welfare), the Attorney General's Office, Department of Education, Department of Health, Department of Rehabilitation, Division of Medicaid, Community Mental Health, family/parents, family-operated agencies, youth/young adults, a psychiatrist and representatives from the DMH to include behavioral health, substance abuse and intellectual/developmental disabilities. The ISCC meets quarterly to coordinate training, coordinate services, build local infrastructure, exchange data, apply for grants and also serve as the oversight governance council for all system of care projects in the state. Local Making A Plan (MAP) Teams develop family-driven, youth guided plans to meet the needs of children and youth referred while building on the strengths of the child/youth and their family. Members of each local team include family members, the community mental health service providers, county human services (family and children's social services) staff, local school staff, as well as staff from county youth services (juvenile justice), health department and rehabilitation services.

The DMH, Division of Children & Youth Services provides funding to the University of Southern Mississippi, School of Social Work to establish the Mississippi Wraparound Initiative (MWI). MWI has four national certified Wraparound Coaches and utilizes the University of Maryland's Innovation Institute model and curriculum of Wraparound Facilitation. MWI facilitates monthly trainings to include Introduction to Wraparound, Engagement, Analysis and Supervisor training. The Division provides funding and coordination of learning collaboratives for Trauma-focused Cognitive Behavioral Therapy (TF-CBT) and Structured Psychotherapy for Adolescents Responding the Chronic Stress (SPARCS) annually. Numerous DMH staff are certified trainers in Mental Health First Aid for Youth (MHFA-Y) and Applied Suicide Intervention Skills Training (ASIST), safe TALK, and Question, Refer and Persuade (QPR). DMH trainers provide trainings upon requests to community mental health providers, law enforcement, mobile crisis teams, schools, child welfare staff, social workers, peer support specialists and other child-serving agencies.

The DMH collects data on service utilization through the Central Data Repository (CDR). Providers of mental health services collect and input data into the CDR on a monthly basis. Additionally, a random sample of individuals representing various age groups, ethnicities, and backgrounds participate in statewide consumer satisfaction surveys through their local CMHCs. Results of these surveys are utilized to assess the quality of services being provided in the CMHCs and assist DMH in supporting and guiding service development. The DMH Division of Children and Youth Services gains additional information from both the individual service level and from a broader system policy level through regular interaction with representatives in other child service agencies on local Making A Plan (MAP) Teams, and through the work of the State-Level Interagency Case Review Team, and a System of Care initiative, the Mississippi Transitional Outreach Program, described in more detail in the State Plan. Furthermore, The DMH management staff receives regular reports from the Division of Office of Consumer Support (OCS), which tracks requests for services by major category, as well as receives and attempts to resolve complaints and grievances regarding programs operated and/or certified by the agency. This avenue allows for additional information that may be provided by individuals who are not currently being served through the public system. Finally, through an ongoing certification and review process, the DMH ensures implementation of services which meet the established operational standards.

The DMH has continued its efforts to provide community mental health services to schools, which is an important strategy in increasing the accessibility of services in rural areas and for families with working parent(s)/caregiver(s). Working with schools to identify and meet the mental health needs of children is also key to improving school attendance and performance of youth with serious emotional or behavioral challenges. School-based therapists employed by the CMHCs continue to offer and provide as requested mental health services in the local schools, including school-based outpatient and school-based day treatment programs as described in the State Plan. Interagency agreements between schools and CMHCs providing school-based Services are verified on monitoring visits by DMH staff.

In Mississippi, Children and adolescents with a serious emotional disturbance are defined as any individual, from birth up to age 21, who meets one of the eligible diagnostic categories as determined by the current DSM and the identified disorder has resulted in functional impairment in basic living skills, instrumental living skills, or social skills. The Division of Children and Youth Services, the Division of Adult Community Services and the Bureau of Alcohol and Drug Abuse have made a concerted effort to better address issues of youth transitioning from the child to the adult system, including needs specific to youth in the age group of 18 to 25 years. The Transitional Services Task Force was formed to better identify and plan to assess needs of youth, age 16 to 25 years. This task force, now called the Executive Steering Committee, has focused on expanding the age range of children/youth identified as transitional-age to include children/youth as young as age 14, the age at which children/youth begin to fall out of the system. The Executive Steering Committee includes representatives from a local mental health center, the Division of Medicaid, the Office of the Attorney General and the DMH Bureau of Community Services. The work of this committee and its members assisted in the development of successful grant applications for a Children's Mental Health Initiative targeting transition – aged youth. This six-year System of Care grant is providing funds for the implementation of three Transitional Outreach Programs (MTOP) across the state and most recently, a four-year grant that expands MTOP to two additional counties. In addition, the DMH Division of Children and Youth Services also provides funding for providers of transitional living services programs that address the needs of youth with SED, including those in the transition age range of 16 to 21 years. The DMH provides funding to four of the six DMH certified transitional therapeutic group homes.

22. Support of State Partners

Role of Other State Agencies in the Delivery of Behavioral Health Services

In Mississippi, coordination of services is a cooperative effort across major service agencies in the provision of the System of Care. Representatives from various State agencies participate on the Mississippi State Mental Health Planning and Advisory Council and serve as liaisons between their respective agencies and the Mississippi Department of Mental Health. Letters of Support from the Division of Medicaid, the Mississippi Department of Human Services, the Mississippi Department of Health, the Mississippi Department of Rehabilitation Services, the Lauderdale Sheriff's Department, the Mississippi Department of Human Services/Division of Youth, the Mississippi Department of Public Safety, the MS Band of Choctaws, Mississippi Department of Education, and MEMA will be submitted with the state plan application.

These state agency partners provided the following information:

Division of Medicaid, Office of the Governor

(Adults)

All children on Medicaid are eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, which include offering medical and dental services from Medicaid providers of those services if needed, as part of the treatment component of the EPSDT process. The DMH Operational Standards also require that residential programs for children with serious emotional disturbance have in place plans for providing medical and dental services.

Mississippi Health Benefits is a cumulative term for the programs available for uninsured children. These include traditional Medicaid and the Children's Health Insurance Program. The same application is used by individuals to apply for Mississippi Medicaid and CHIP. Children are tested for Medicaid eligibility first. If ineligible for Medicaid, the application is screened for CHIP. Applications and redeterminations can be made at the 30 Regional Medicaid Offices, as well as additional outstation locations. Outstation locations include: local health departments, hospitals, and Federally Qualified Health Centers.

The Mississippi Division of Medicaid submitted a successful application in 2006 for a five-year demonstration grant for Community-based Alternatives to Psychiatric Residential Treatment Facilities (CA-PRTF) program, one of 10 PRTF Demonstration Projects approved that year by the federal Centers for Medicare and Medicaid Services (CMS). The name of the program is Mississippi Youth Programs Around the Clock (MYPAC). Funds from this grant have assisted Mississippi in developing home- and community-based alternatives to residential treatment or institutionalization and significantly assist Mississippi in further developing and implementing a strong infrastructure, particularly for the one to three percent of the population with the most intensive needs targeted. The maximum unduplicated count of youth to be served through the program over the five-year project was 1970. Programs approved for funding under this demonstration grant include 24-hour support and crisis intervention in the community setting, training for families, respite care for those families, and wrap around teams who develop individual service plans. The successful outcomes from the MYPAC demonstration program were shorter lengths of stay at PRTFs, diversion from PRTF admissions, more coordinated treatment for youth with Serious Emotional Disturbance (SED), a reduction in the overall cost to the State, and an improved system of care for youth with SED.

The Department of Mental Health worked with the Division of Medicaid to develop a proposed State Plan Amendment submission to the Centers for Medicare and Medicaid Services (CMS) for MYPAC to sustain as a mental health rehabilitative service. CMS approved MYPAC as a state plan rehabilitative service on January 1, 2013, which continues to facilitate changes in community

mental health services to further support resilience/recovery. The Division of Community Services in the Department of Mental Health plans to continue regular communication and collaborative efforts with the Office of Mental Health in the Division of Medicaid to effectively administer the community mental health service program for adults.

In February 2011, the Mississippi Division of Medicaid was one of 13 states awarded the Money Follows the Person demonstration grant. The state will receive $37 million over the next six years. The Department of Mental Health has worked closely with the Division of Medicaid to assist in this effort. It is anticipated that demonstration will increase the ratio of community-based service spending compared to institutional spending over the course of the six-year grant. Cost savings achieved by transitioning people out of institutions will be directed into community-based services. This will help to eliminate barriers that prevent or restrict flexible use of Medicaid funds and enable individuals to receive long-term care in the setting of their choice. The goal of the demonstration project is to help 595 persons with disabilities or the elderly transition out of institutions by 2017.

Health/Medical/Dental Services are accessed through case management for children of all ages with serious emotional disturbance. These services are provided through a variety of community resources, such as through community health centers/clinics, county health department offices, university programs and services and private practitioners.

Outpatient health and medical care is also available in the state through federally funded Community Health Centers in the state. As of May, 2009, there were 21 Community Health Centers with 165 service delivery sites in Mississippi serving approximately 310,000 patients and further advancing President Obama's effort to provide access to health care for all Americans. Community Health Centers are located in high need areas identified as having elevated poverty, higher than average infant mortality, and where few physicians practice. These health centers tailor services to meet the special needs and priorities of their communities. The centers are staffed by a team of board certified/eligible physicians and dentists, nurse practitioners, nurses, social workers, and other ancillary providers who provide high quality care, thus reducing health disparities and improving patient outcomes. The centers provide comprehensive primary and preventive health services, including medicine, dentistry, radiology, pharmacy, nutrition, health education, social services and transportation. Federally subsidized health centers must, by law, serve populations identified by the Public Health Service as medically underserved, that is, in areas where there are few medical resources. Generally, approximately 50% of health center patients have neither private nor public insurance. Patients are given the opportunity to pay for services on a sliding fee scale. However, no one is refused care due to inability to pay for services. These community health centers provide cost effective care and reduce emergency room, hospital and specialty care visits, thus saving the health care system between $9.9 and $17.6 billion a year. The Mississippi Primary Health Care Association (MPHCA) is a nonprofit organization representing 21 Community Health Centers (CHCs) in the state and other community-based health providers in efforts to improve access to health care for the medically underserved and indigent populations of Mississippi.

The MS Department of Health (DOH) also makes available certain Child Health Services statewide to children living at or below 185 percent of the non-farm poverty level and to other children with poor access to healthcare. The Child Health services include childhood immunizations, well-child assessments, limited sick child care, and tracking of infants and other high risk children. Through other internal programs and community initiatives, the Department of Health works to address issues such as teen pregnancy, tobacco use, unintentional injuries, and promotes specific interventions to decrease infant mortality and morbidity. Services are preventive in nature and designed for early identification of disabling conditions. Children in need of further care are linked with other State Department of Health programs and/or private care providers necessary for

effective treatment and management. The Department of Health also administers the Children's Medical Program, which provides medical and/or surgical care to children with chronic or disabling conditions, available to state residents up to 21 years of age.

Conditions covered include major orthopedic, neurological, cardiac, and other chronic conditions, such as cystic fibrosis, sickle cell anemia and hemophilia. Each Public Health District has dedicated staff to assist with case management needs for children with special health care needs and their families. The Department of Health (DOH) is the lead agency for the interagency early intervention system of services for infants and toddlers (birth to age three) with developmental disabilities. First Steps Early Intervention Program's statewide system of services is an entitlement for children with developmental disabilities and their families. Additionally, the DOH administers WIC, a special supplemental food and nutrition education program for infants and preschool children who have nutrition-related risk conditions. The DOH partners with other state agencies and organizations to address child and adolescent issues through active participation with, but not limited to, the local MAP teams, State-Level Case Reviews, Youth Suicide Prevention Advisory Council, and the Interagency System of Care Council.

Included in the CHIP program is coverage for dental services, which includes preventive, diagnostic and routine filling services. Other dental care is covered if it is warranted as a result of an accident or a medically-associated diagnosis. During the 2001 Legislative Session, legislation was passed authorizing the expansion of dental coverage in CHIP Phase II, which was effective January 1, 2002. The expanded dental benefit includes some restorative, endodontic, periodontic and surgical dental services. The establishment of a dental provider network was also authorized, making dentists more accessible. Historically, there has been poor participation by dentists in the State Medicaid program due to low reimbursement rates primarily. House Bill 528, passed in the 2007 Legislative Session and signed by Governor Barbour establishes a fee revision for dental services as an incentive to increase the number of dentists who actively provide Medicaid services. A new dental fee schedule became effective July 1, 2007, for dental services. In addition, a limit of $2500 per beneficiary per fiscal year for dental services and $4200 per child per lifetime for orthodontia was established, with additional services being available upon prior approval by the Division of Medicaid.

The Mississippi Department of Health's Office of Oral Health assesses oral health status and needs and mobilizes community partnerships to link people to population-based oral health services to improve the oral health of Mississippi children and families. The Mississippi Regional Oral Health Consultants are licensed dental hygienists in each Public Health District who perform oral health screening and education and provide preventive flouride varnish applications to prioritized populations, such as children enrolled in Head Start programs. The Public Water Fluoridation Program is collaboration with the Bower Foundation to provide grant funds to public water systems to install community water fluoridation programs.

The Mississippi State Department of Health (MSDH) recommends that every child begin to receive oral health risk assessments by 6 months of age by a qualified pediatrician or a qualified pediatric health care professional. The MSDH Office of Oral Health can provide guidance on how to perform an oral health risk assessment and several risk assessment tools are available through the American Academy of Pediatrics, the American Association of Pediatric Dentistry, and the American Dental Association. Groups at higher risk for having dental caries, or tooth decay, include children with special health care needs, children of mothers with a high dental caries rate, children with demonstrable dental caries, plaque, demineralization, and/or staining, children who sleep with a bottle or breastfeed throughout the night, later-order offspring, and children in families of low socioeconomic status. The MSDH recommends that infants in risk groups should be

referred to a dentist as early as 6 months of age and no later than 6 months after the first tooth erupts or 12 months of age (whichever comes first) for establishment of a dental home with education and early prevention services.

The Primary Health Care Association reports that the availability of dental care and oral health care for underprivileged individuals has increased in communities where federally-funded Community Health Centers are located. Currently, 19 of the 21 Community Health Centers (CHCs), offer oral health services. Two of the CHCs receive federal funding to provide health care to the homeless populations, focusing on mental health and substance abuse, in addition to medical care. Oral health and mental health services are considered priorities for expansion by the Health Resources and Services Administration's Bureau of Primary Health Care, further advancing President Obama's effort to provide access to health care for all Americans.

Health/Medical/Dental Services are addressed by community mental health centers with other support services to adults with serious mental illness as part of local CSP plans, which are required as part of local providers' applications for CMHS block grant funds. CMHCs provide medical and dental services in a variety of ways, with the primary avenues being: 1) use of community health centers; 2) use of State Department of Health county health offices/services; 3) pro bono work by physicians and dentists; 4) University Medical Center services; 5) contributions by mental health associations and other local nonprofit/charitable organizations; 6) emergency medical/dental funds maintained by the provider program, including DMH funding for purchase of psychotropic medications; and 7) contributions by individuals and businesses. Of course, some medical and dental services are paid through the Medicaid and Medicare programs.

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Division of Medicaid

(Children)

Health/Medical/Dental Services are accessed through case management for children of all ages with serious emotional disturbance. These services are provided through a variety of community resources, such as through community health centers/clinics, county health department offices, university programs and services and private practitioners.

Outpatient health and medical care is also available in the state through federally funded Community Health Centers in the state. As of May, 2009, there were 21 Community Health Centers with 165 service delivery sites in Mississippi serving approximately 310,000 patients and further advancing President Obama's effort to provide access to health care for all Americans. Community Health Centers are located in high need areas identified as having elevated poverty, higher than average infant mortality, and where few physicians practice. These health centers tailor services to meet the special needs and priorities of their communities. The centers are staffed by a team of board certified/eligible physicians and dentists, nurse practitioners, nurses, social workers, and other ancillary providers who provide high quality care, thus reducing health disparities and improving patient outcomes. The centers provide comprehensive primary and preventive health services, including medicine, dentistry, radiology, pharmacy, nutrition, health education, social services and transportation. Federally subsidized health centers must, by law, serve populations identified by the Public Health Service as medically underserved, that is, in areas where there are few medical resources. Generally, approximately 50% of health center patients have neither private nor public insurance. Patients are given the opportunity to pay for services on a sliding fee scale.

However, no one is refused care due to inability to pay for services. These community health centers provide cost effective care and reduce emergency room, hospital and specialty care visits, thus saving the health care system between $9.9 and $17.6 billion a year. The Mississippi Primary Health Care Association (MPHCA) is a nonprofit organization representing 21 Community Health Centers (CHCs) in the state and other community-based health providers in efforts to improve access to health care for the medically underserved and indigent populations of Mississippi.

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Conditions covered include major orthopedic, neurological, cardiac, and other chronic conditions, such as cystic fibrosis, sickle cell anemia and hemophilia. Each Public Health District has dedicated staff to assist with case management needs for children with special health care needs and their families. The Department of Health (DOH) is the lead agency for the interagency early intervention system of services for infants and toddlers (birth to age three) with developmental disabilities. First Steps Early Intervention Program's statewide system of services is an entitlement for children with developmental disabilities and their families. Additionally, the DOH administers WIC, a special supplemental food and nutrition education program for infants and preschool children who have nutrition-related risk conditions. The DOH partners with other state agencies and organizations to address child and adolescent issues through active participation with, but not limited to, the local MAP teams, State-Level Case Reviews, Youth Suicide Prevention Advisory Council, and the Interagency System of Care Council.

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data on private chemical dependency treatment facilities it licenses and reported 52 licensed and/or Certificate of Need (CON) approved beds in FY 2011 for adolescents and 279 licensed and/or Certificate of Need (CON) approved beds in FY 2011 for adults. The MS Department of Mental Health does not collect data from hospitals in the private sector; this information is maintained by the Mississippi State Department of Health, which licenses those facilities.

The University of Mississippi Medical Center (UMMC), Department of Psychiatry and Human Behavior has continued efforts to integrate psychiatry residents in public mental health settings. Rotations for residents in adult psychiatry continue at Mississippi State Hospital (MSH); these residents also complete rotations on the child/adolescent acute psychiatric unit (Oak Circle Center). A rotation for senior psychiatry residents has been established in the public community mental health setting in Region 9, at Hinds Behavioral Health Services in Jackson, and planning is proceeding to establish another rotation in the metro Jackson area. Many of the staff at MS State Hospital are on the affiliate faculty at UMMC, as are some providers at local community mental health centers. Clinical psychology residents and faculty are collaborating with Harbor House (nonprofit community treatment program for adults with substance abuse problems); psychology residents and child psychiatry residents also have clinical rotations at Mississippi Children's Home Society/CARES, a nonprofit program serving youth. Additionally, two UMMC child psychiatrists and fellows provide services at the Oakley Training School, and plans are under development regarding provision of psychiatric services via telehealth by UMMC clinical staff to a facility operated through the Mississippi Department of Corrections.

Social Services/Protective Services: Mississippi Department of Human Services, Division of Family and Children's Services

Social services and financial assistance are available through programs administered by the Mississippi Department of Human Services (MDHS) for families/children who meet eligibility criteria for those specific programs. The DHS Division of Family and Children's Services provides child protective services, child abuse/neglect prevention, family preservation/reunification, foster care, adoption, post adoption services, emergency shelters, comprehensive residential care, therapeutic foster homes, therapeutic group homes, intensive in-home services, foster teen independent living, interstate compact, child placing agency/residential child care agency licensure, and case management. The DHS Division of Family and Children's Services and the Division of Youth Services work closely with the Department of Mental Health through participation on the Mississippi State Mental Health Planning Council, MAP teams, and other committees. The DHS Division of Field Operations provides Temporary Assistance for Needy Families (TANF), TANF Work Program (TWP), child support enforcement and location, Supplemental Nutrition Assistance Program (SNAP), the Disaster Supplemental Nutrition Assistance Program (DSNAP), the Emergency Food Assistance Program (TEFAP), and SNAP Nutrition Education (SNAP-Ed). The DHS Division of Youth Services provides counseling, delinquency probation supervision, and Adolescent Offender Programs (AOPs), Interstate Compact for Juveniles, and oversees the state training schools. The DHS Division of Family Foundation and Support provides child support legal and collection services, Healthy Marriage, Teen Pregnancy, and Fatherhood initiatives as well as the Access and Visitation Program for non-custodial parent visitation. The DHS Division of Children and Youth provides certificates for child care services for TANF clients, child welfare clients, and some working foster parents. The DHS Division of Aging and Adult Services (DAAS) plans, advocates for, and coordinates the delivery of services to adults 60 years of age and older through a system of local Area Agencies on Aging (AAAs). The DAAS's goal is to provide support services to help people remain in their own homes and local communities. The DAAS developed a single point of entry system for the aged and adult population with disabilities: the Aging and Disability Resource Center, called Mississippi Get Help. The project was piloted in

central Mississippi and continues to expand services statewide with a toll-free, telephonic, virtual web-based, and face-to-face resource center that provides access to information, as well as assistance in applying for services. The "no wrong door" approach assures the public consistent information and assistance. In addition, it helps the public navigate through what can seem like a maze of government assistance, as well as the private and nonprofit service system. The Division of Aging and Adult Services also investigates abuse, neglect, and exploitation of vulnerable adults, ages 18 and older in private settings, under the Adult Protective Services program. The DHS Division of Community Services provides services such as homeless resource referrals and low income utility assistance. Additional social services and financial assistance are accessed as needed for adults with serious mental illness and are administered through various public service agencies/organizations, such as the MS Department of Human Services (described above), the Division of Medicaid, the Department of Health, the Social Security Administration, the Cooperative Extension Service, the Salvation Army, churches, etc. Examples of this assistance include SNAP benefits, medical/other financial assistance, nutrition services, protective services, transportation, financial counseling, etc.

Justice Services

The DMH has an agreement with the MS Department of Public Safety (DPS). Professional mental health staff from the community mental health centers (CMHC) to provide education to police recruits as part of their required training at the Law Enforcement Academies and to other law enforcement personnel, as requested. Certified Mental Health First Aid instructors provide MHFA (mental health first aid training) to law enforcement agencies and officers. The officers receive approved continuing education credits from DPS.

Lauderdale County has established the Lauderdale County Community Partnership (LCCP) to develop a Crisis Intervention Team (CIT) program in Meridian. The partnership includes members from Lauderdale County Sheriff's Department, Meridian Police Department, Weems Community Mental Health Center, Alliance Health Center, Rush Hospital, Riley Hospital, Anderson Regional Medical Center, NAMI, Central Mississippi Residential Center, and the DMH. The single point of entry for the CIT program is the Newton CSU. To date, LCCP has conducted seven 40 hour training classes and graduated 85 CIT officers. Another class is scheduled for August 2015 with an expected 15 officers attending.

The DMH has entered into a contract with Lauderdale County Sheriff's Department to allow officers from around the state to attend CIT training in Meridian at no cost to the other law enforcement agencies. The DMH has mailed letters, brochures and a video promoting the CIT training opportunity to all 82 sheriff's departments and to 49 of the major police department around the state.

Governor Phil Bryant declared February 2015 CIT Awareness month.

The DMH has partnered with DPS to recognize officers who have completed CIT training. Officers completing CIT training receive a certificate from the DMH and DPS signed by Ms. Diana Mikula and Commissioner Santa Cruz and they get 40 hours of CEs from DPS.

Protection and Advocacy: Disability Rights Mississippi

Disability Rights Mississippi (DRMS) is a private, nonprofit corporation established to protect and advocate for the rights of individuals with disabilities in Mississippi. Disability Rights Mississippi

is independent of any agency, organization, or governmental unit providing treatment, services, or habilitation to individuals with disabilities. The agency provides information, referral, outreach, training, short term assistance, and legal advocacy. A Board of Directors governs the agency. The purpose of Protection and Advocacy for Individuals with Mental Illness (PAIMI) program within Disability Rights Mississippi is to protect and advocate for the rights of persons with mental illness. The PAIMI program has an active Advisory Committee (PAC) and the majority of its members are individuals diagnosed with mental illness or family members of such individuals. Services provided through the PAIMI program include information and referral; technical assistance; advice and support for persons who plan to advocate for themselves, their rights and needed services; assistance in meetings and negotiations; representation in administrative appeals and hearings; and litigation, usually in cases where the outcome could benefit many individuals. Additional services designed to enhance the rights of all persons labeled mentally ill include: public information and education regarding the needs and rights of persons labeled mentally ill; monitoring of state institutions and private and public psychiatric hospitals; investigations of allegations of serious abuse or neglect; identification of problems in the systems of service delivery; and advocacy to improve the service delivery system. DRMS provides advocacy and legal assistance to persons with mental illness living in a variety of settings, including jails, personal care homes, detention facilities, group homes, nursing homes, and those living independently.

Families As Allies

The Division of Children and Youth continues to provide financial support to Families as Allies, the only family-run statewide organization for parents and caregivers of children with mental health challenges in Mississippi. Families as Allies is the State Chapter of the National Federation of Families for Children's Mental Health and the recipient of SAMHSA's Statewide Family Network grant. Families as Allies' Mission is to make sure families are partners in their children's care and its core values are valuing every child and family, partnership, excellence and accountability. Families as Allies provides a wide array of family-to-family support, education and advocacy opportunities and works at the policy level to challenge all of the child-serving systems to reflect the same core values in their work.

CMHS block grant monies fund Family Partners who provide support and referral services to families who call from throughout the state. These same Family Partners attend meetings with families, assist them in writing letters and filing relevant complaints, facilitate group activities and teach advocacy skills. Respite care by specially trained workers is provided at all group family activities and also funded through block grant funds. Families as Allies responds to about 150 calls per month and staff attends about 60 family meetings, 15 – 20 policy meetings and conduct five – six community outreach activities during the same time period. Over the past year, a number of board development activities have been conducted and documentation of program, personnel and financial data has become more systematic in preparation for electronic record keeping. Increased use of social media and Constant Contact has allowed broader and more comprehensive feedback from families to determine unmet needs, including participation in a comprehensive assessment of the Children's SOC completed by the Technical Assistance Collaborative.

Under the Statewide Family network grant, Family Partners provide technical assistance to families to find support and create system change in different regions while still developing a comprehensive statewide family network. This work has led to Families as Allies developing a Leadership Training curriculum that has been conducted with families five times over the past year. It also serves as the foundation for a comprehensive curriculum for Parent Support Providers that is consistent with the national core competencies and certification exam. Families as Allies is working on the curriculum in partnership with other state family organizations, FREDLA and the Federation and anticipates it being complete within the next year. Families as Allies also provides

the MAP Teams with technical assistance on SOC principles, especially to help family-driven care, and hopes to do the same with the other statutorily mandated SOC committees when they are meeting more regularly.

Educational Services: Mississippi State Department of Education

Programs that provide services for children with mental health needs are available and accessible in the regular education setting as well as the special education arena. In Mississippi, there are fifteen (15) Regional Mental Health Centers (RMHC), with each location being responsible for provision of services to local school districts via interagency agreements. All fifteen RMHCs are required to have interagency agreements with each local school district in their region. As a result of this agreement, the number of students receiving services for assistance with emotional and behavioral disabilities while attending general and/or special education is approximately 33,350. Statewide initiatives such as those on suicide prevention, bullying, and cybercrimes (sexting) have also played a large role in providing assistance to all students.

In addition, interagency collaboration among local community mental health centers/other nonprofit mental health service providers is encouraged and facilitated through interagency councils in some areas of the state. In most regions, CMHCs and local school districts have collaborative arrangements to provide day treatment and other outpatient mental health services. The state psychiatric hospitals operate accredited special school programs as part of their inpatient child and adolescent treatment units and collaborate with local school districts, from referral through discharge planning. Section 504 Teacher Units are also approved through the Department of Education to local school districts for community residential programs for adolescents with substance abuse problems and other areas under Section 504 criteria. Headstart programs also serve some preschoolers with disabilities, including children with emotional problems. Children with serious emotional disturbance who meet eligibility criteria for a disability in accordance with state and federal special education guidelines have access to educational services provided through local public school districts in the state. A free appropriate public education (FAPE) must be available to all children residing in the State between the ages of three through 20, including children with disabilities who have been suspended or expelled from school. A FAPE means special education and related services that are provided in conformity with an Individualized Education Program (IEP). After a multidisciplinary evaluation team determines a student with a disability meets the required criteria under IDEA 2004, the (IEP) Committee meets to determine the educational needs and related services of the individual, including the accommodations, modifications and supports that must be provided for the child in accordance with the IEP in the least restrictive environment. Those services could include a functional behavioral assessment, behavioral intervention plan, and other positive behavioral interventions and supports determined by the IEP Committee. Each district must ensure that a continuum of alternative placements is available to meet the needs of children with disabilities who reside within their jurisdiction for the provision of special education and related services. It is the IEP Committee, which includes the parents, that determines the appropriate special education and related services (including transition services) and placement of a student with a disability. Any related service required by a student necessary to benefit from their special education services and any transition services determined appropriate by the IEP Committee must be provided at no cost to the parent. These related services include, but are not limited to: Audiology, Counseling, Early Identification and Assessment of Disabilities in Children, Interpreting Services, Medical Services, Occupational Therapy, Orientation and Mobility Services, Parent Counseling and Training, Physical Therapy, Psychological Services, Recreation, Rehabilitation Counseling Services, School Health Services and School Nurse Services, Social Work Services, Speech-Language Pathology, and Transportation. All districts in the State must provide all services as determined by the IEP Committee in accordance with the IEP.

Updated at least annually, the IEP must include a statement of the transition services needs of the child, beginning at age 14 (or younger, if determined appropriate by the IEP Committee). These transition services include coordination of services with agencies involved in supporting the transition of students with disabilities to postsecondary activities. Transition activities include instruction, related services, community experiences, the development of employment and other post-school adult living objectives, and if appropriate, the acquisition of daily living skills and provision of a functional vocational evaluation. Community-based activities, including job shadowing, on-the-job training, as well as part-time employment, are also provided if determined appropriate by the IEP Committee. The IEP must also have a desired post-school outcome statement. This statement should address areas of post-school activities/goals, including post-secondary education, vocational education, integrated employment (including supported employment), continuing and adult education, adult services, independent living and/or community participation.

Students Ruled EmD under the Individuals with Disabilities Education Act of (2004)
IDEA 2004 defines emotional disturbance as a condition in which a child exhibits one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child's educational performance: inability to learn that cannot be explained by intellectual, sensory or health factors; inability to build or maintain satisfactory interpersonal relationships with peers and/or teachers; inappropriate types of behavior or feelings under normal circumstances; general pervasive mood of unhappiness or depression; and/or tendency to develop physical symptoms or fears associated with personal or school problems. Emotional disturbance includes schizophrenia and does not apply to children who are socially maladjusted, unless it is determined that they have an emotional disturbance.

Other Educational Services and Initiatives
The Division of Parent Outreach within the Mississippi Department of Education, Office of Special Education (OSE), provides information and training in areas of identified need to parents, students, and community organizations. This division works to build collaborative relationships with parents and organizations interested in services to children with disabilities. This division also provides the following: training regarding parental rights and services under IDEA 2004; development and distribution of materials for parents; handling of parent complaints, mediation, Resolution Sessions, and due process hearings; and conducting meetings with stakeholders.

The Office of Dropout Prevention and Compulsory School Attendance Enforcement has an annual conference that focuses on dropout prevention, behavioral modification, alternative education and counseling. Additionally, from the Office of Healthy Schools, the public schools in Mississippi are being required to conduct a school health needs assessment that addresses counseling, psychological services and the needs assessment. One of the eight components of the Center for Disease Control and Prevention's (CDC) coordinated school health is counseling and psychological services. In accordance with this component, Mississippi public schools are required to establish a local school wellness policy.

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The MS Department of Health (MSDH) also makes available certain specialized health care programs. Through other internal programs and community initiatives, MSDH works to address issues such as teen pregnancy, tobacco use, and unintentional injuries, and to promote specific interventions to decrease infant mortality.

Outpatient mental health services are also available through licensed practitioners in the private sector, whose scope of practice and services are regulated by their respective licensure boards/agencies and payors of their services (insurance programs, Medicaid, etc.). The Department of Health, which collects data on psychiatric facilities it licenses, reported 270 licensed and/or CON approved inpatient beds for adolescent acute psychiatric services (excluding the state-operated MS State Hospital and East MS State Hospital units) and 535 licensed/inpatient beds, with an additional two beds held in abeyance and 24 CON approved beds by MSDH for psychiatric services for adults in FY 2011. The Department of Health also collects data on private chemical dependency treatment facilities it licenses and reported 52 licensed and/or Certificate of Need (CON) approved beds in FY 2011 for adolescents and 279 licensed and/or Certificate of Need (CON) approved beds in FY 2011 for adults. The MS Department of Mental Health does not collect data from hospitals in the private sector; this information is maintained by the Mississippi State Department of Health, which licenses those facilities.

The University of Mississippi Medical Center (UMMC), Department of Psychiatry and Human Behavior has continued efforts to integrate psychiatry residents in public mental health settings. Rotations for residents in adult psychiatry continue at Mississippi State Hospital (MSH); these residents also complete rotations on the child/adolescent acute psychiatric unit (Oak Circle Center). A rotation for senior psychiatry residents has been established in the public community mental health setting in Region 9, at Hinds Behavioral Health Services in Jackson, and planning is proceeding to establish another rotation in the metro Jackson area. Many of the staff at MS State Hospital are on the affiliate faculty at UMMC, as are some providers at local community mental health centers. Clinical psychology residents and faculty are collaborating with Harbor House (nonprofit community treatment program for adults with substance abuse problems); psychology residents and child psychiatry residents also have clinical rotations at Mississippi Children's Home Society/CARES, a nonprofit program serving youth. Additionally, two UMMC child psychiatrists and fellows provide services at the Oakley Training School, and plans are under development regarding provision of psychiatric services via telehealth by UMMC clinical staff to a facility operated through the Mississippi Department of Corrections.

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health Block Grant Application

Council members received information on the instructions provided by SAMHSA throughout the plan development process. The process to make a State Plan Draft available for review by the Council and the public proceeded along timelines specified by SAMHSA. These timelines allowed sufficient time for public review and comment and compliance with the federal submission timeline.

In accordance with the Council's procedures, the Department of Mental Health's staff provided reports on major initiatives planned for FY 2016-2017 at the April 23, 2015 Planning Council meeting. The Council had the opportunity for further review of the Draft State Plan during the 30 day comment period (June 5, 2015 through July 5, 2015). The Council approved the Draft State Plan at the July 9, 2015 Mississippi State Mental Health Planning and Advisory Council meeting. The Final State Plan was approved by the Council at the July 9, 2015 meeting.

The Council met January 29, 2015, April 23, 2015, and April 23, 2015. The next Planning Council meeting is scheduled for November 12, 2015.

SECTION V
ATTACHMENTS

APPENDIX A

APPENDIX B

APPENDIX C

APPENDIX D

APPENDIX E